Juvenile Defender Newsletter

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Representing Parents and Children in Serious Physical Abuse Cases

An infant is brought to the emergency department of a local hospital after he vomits inexplicably and appears to suffer a seizure. Imaging reveals a subdural hematoma and the attending pediatrician reports the injury as suspected child abuse. A three-year old with limited verbal abilities is brought to the emergency department with a broken arm. She tells the treating physician that "daddy hurt my arm," but subsequently says she fell off a table. Meanwhile, the medical evidence could support either an accidental or intentional mechanism of injury. Serious physical abuse cases like these present unique challenges for attorneys. The goal of this article is to help attorneys examine the quality of the evidence supporting conclusions about the nature and cause of a child's unexplained injuries.

The children at the center of serious, unexplained injury cases are often unable to communicate effectively due to age or disability. These cases can be very challenging for all parties involved. The most difficult cases combine a high degree of risk with a significant level uncertainty about whether the injury was accidental, or if the injury was not accidental, who caused it. In such situations, the stakes are very high. An incorrect decision could place the child at serious risk of further injury or even death, or it could result in the needless and traumatic separation of a child from loving parents.

A typical report comes from a medical provider who is concerned about an unexplained injury or an injury that does not appear to match the caregiver's explanation. At the point that he or she is making the report, the medical professional has typically not ruled out accidental or medical causes for the injury. That determination will often rely on a combination of medical testing, expert opinion, and investigation by DCF and law enforcement. Unfortunately, the accuracy of any conclusion depends to a great extent on the reliability of the medical evidence and on the quality of the investigation. Faulty science, assumptions, stereotypes, and inaccurate or incomplete investigations can result in unnecessary removals and the criminal conviction of an innocent person. Therefore, it is especially important that attorneys carefully review the

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investigation and obtain expert assistance in evaluating the quality of medical evidence.

The results of a year-long investigation by NBC News and the Houston Chronical reveal a disturbing pattern of misdiagnosis by pediatricians specializing in diagnosing child abuse.[1] Unfortunately, medical experts can make mistakes, and effective advocacy might be your client's last chance to rectify the erroneous removal of his or her child (and an erroneous criminal conviction). Attorneys representing parents in such cases should take the following steps to challenge medical evidence supporting a conclusion of child abuse:[2]

1) Get discovery.

Obtain all relevant medical records. Sometimes, an alternative explanation for the injury or impairment that led to a diagnosis of child abuse will be evident from the records, even to a lay person. Obtain recordings or summaries of all interviews conducted as part of the case. Obtain the State's expert's report and facts and assumptions underlying the expert's opinion.

2) Find your own expert.

Did any of the child's treating physicians disagree with or question the diagnosis of non-accidental injury? If so, subpoenaing a treating physician is a powerful and inexpensive way to rebut the conclusions of the State's expert witness. If not, look for a physician with expertise in the specialty most relevant to the injury or impairment, such as a pediatric orthopedist in the case of a child with unexplained fractures.

3) With the help of your expert, identify alternative explanation for the injury or impairment.

Underlying medical conditions, such as bleeding disorders or prematurity can explain extensive bruising or bleeding in the brain. Likewise, genetic conditions or vitamin and mineral deficiencies may explain fractures. Another common reason for an erroneous diagnosis of child abuse is failure to properly interpret the results of x-rays or other diagnostic tests. Always get a second opinion.

4) Challenge the State's expert's credentials.

Is the expert board-certified in a relevant subspecialty? Is the expert board-certified as a child abuse pediatrician? In most cases, certification as a child abuse pediatrician requires that the physician complete a three-year fellowship in child-abuse pediatrics and pass a written examination.[3] A frequent critique of pediatricians who specialize in the diagnosis of child abuse is that they may lack the specialized medical knowledge to rule out underlying medical causes and that their focused training in diagnosis child abuse may make them vulnerable to confirmation bias. The Family Defense Center has an excellent resource for attorneys seeking a critical perspective on child abuse pediatrics as a subspecialty.[4]

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[1] https://www.nbcnews.com/news/us-news/do-no-harm

[2] Rachelle Hatcher and Richard E. Gutierrez, Combating Medical Experts in Abuse and Neglect Cases under the Juvenile Court Act, American Bar Association, Aug. 31, 2017, https://www.americanbar.org/groups/litigation/committees/jiop/articles/2017/summer2017-combating-medical-experts-abuse-neglect-cases-juvenile-court-act/

[3] American Board of Pediatrics, Child Abuse Pediatrics Certification, https://www.abp.org/content/child-abuse-pediatrics-certification

[4] George J. Barry and Diane L. Redleaf, The Family Defense Center, *Medical Ethics Concerns in Physical Child Abuse Investigations: A Critical Perspective*,

Their article focuses on ethics and may help attorneys in developing their cross-examination of a child abuse pediatrician.

5) Challenge the facts and assumptions underlying the expert's opinion.

Did the expert rely on assumptions or "facts" that cannot be proven? For example, the pediatrician may testify that the child sustained rib fractures in four different places, but there may be dispute as to whether the imaging shows any rib fractures at all. Likewise, it is important to listen to interview recordings and conduct your own interviews of witnesses. The expert's opinion, or the conclusions that may be drawn from it, may be based on inaccurate information such as mischaracterized witness statements.

The above suggestions are a starting point for challenging the reliability of a medical professional's opinion that abuse was the cause of an unexplained injury or impairment. But what should you do when the medical evidence unequivocally supports a finding of abuse? In some cases, the medical evidence will point to a finding of abuse, but the identity of the perpetrator may be unknown. In such cases, DCF is likely to regard everyone who had access to the child as a potential perpetrator, at least in the early stages of the case. In these situations, children may be separated from non-perpetrating caregivers for extended periods of time, and DCF may substantiate allegations of abuse against multiple caregivers, even when it is almost certain that only one caregiver caused the injury. This approach may serve to mitigate risk, but it results in collateral damage to the relationship between the child and the non-perpetrating caregiver(s). Attorneys should seek a forensic psychological evaluation on behalf of non-perpetrating parents as soon as possible. Make sure your expert interviews collateral informants who have observed your client's parenting over the course of time. Often, an expert opinion regarding parental fitness coupled with a plan to keep the child safe from the alleged perpetrator is enough to secure a return of custody to the non-perpetrating parent. Attorneys should also be prepared to help clients challenge administrative substantiations for physical abuse since such findings may preclude DCF from supporting a return of custody. Attorneys should assist clients in requesting an administrative appeal of a decision to substantiate physical abuse, and they should ask DCF to stay the administrative review pending the outcome of a contesting hearing on the merits.

In summary, a case that appears highly indicative of intentional abuse on its face may quickly fall apart once subjected to scrutiny. Do not give up on your client, and in the case of complicated medical evidence, always seek a second opinion.

The Role of Attorneys in Facilitating Effective Transition Planning for Youth Aging Out of Custody

The transition from childhood to adulthood is challenging for everyone. However, it can be especially challenging for youth who are transitioning out of DCF custody. These youth face significant challenges due to a lack of financial and emotional support.

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https://www.familydefensecenter.net/wp-content/uploads/2016/04/Medical-Ethics-Concerns-in-Physical-Child-Abuse-Investigations-corrected-reposted.pdf

Although, in theory at least, services exist to prevent transition-age youth from becoming homeless, we know that in practice, clients decline these services when they do not agree with the proposed living arrangements or are frustrated by the idea of DCF remaining involved in their lives. Additionally, DCF may fail to assist youth in obtaining services and benefits they are eligible for. This results in clients leaving DCF custody with little social support, no identified place to live, no driver's license or reliable transportation, and no legal way to support themselves once they are on their own. Clients may age out without obtaining any state-issued identification, re-applying for Medicaid, or completing the applications necessary to continue to receive the Social Security benefits that DCF collected on their behalf while they were in custody. Inadequate transition planning can condemn youth to a future of educational underachievement, unemployment, homelessness, poverty, premature parenthood, sex trafficking,[5] and involvement with the criminal justice system.

Effectively enforcing your clients' rights to transition planning and services requires an understanding of applicable federal law, state law, and DCF policies governing transitional services for children and youth. The goal of this article is to provide an overview of applicable laws and offer strategies for ensuring that your clients enter adulthood with as much of what they need to succeed as the law can provide. As you read through the requirements, think about your own transition-age clients and whether DCF is complying with law and policy.

Title IV-E of the Social Security Act imposes several requirements on states as a condition of receiving IV-E funding. These requirements include:

- Case Plan and Permanency Plan

The case plan and permanency plan must be developed in consultation with any youth age 14 or older. The plan must advise the youth of his or her rights, and the youth must have an opportunity to select two members of his or her case and permanency planning team. The plan must also include a description of the programs and services that will help prepare the youth for a successful transition to adulthood. 42 U.S.C. §§ 475(1), 475(5)(C), 475A(b).

- APPLA

APPLA may not be listed as a permanency goal for anyone under the age of 16. Additionally, when APPLA is listed as the goal, DCF must comply with additional requirements designed to ensure that it continues to look for better permanency options and revisit the appropriateness of the APPLA goal periodically. 42 U.S.C. §§ 475(1), 475(5)(C), 475A(a).

- Essential Documents

DCF must conduct annual credit checks on youth in custody and assist youth in resolving any discrepancies. Additionally,

[5] According to Casey Family Programs, youth who spend time in foster care, and especially youth who spend time in congregate care settings, are more likely to become victims of sex trafficking. Casey Family Programs, *Are youth placed in congregate care settings more at risk of future commercial sexual exploitation?*, (May 10, 2018) https://www.casey.org/congregate-care-sex-trafficking/ ("The relationship between congregate care and vulnerability to sex trafficking can become cyclical — not only are children who are placed in congregate care potentially more vulnerable to becoming victims of CSE, as discussed above, but victims of CSE who enter or return to care are often placed in congregate care settings, which can then make them vulnerable to becoming trafficked again.").

DCF must provide youth with any documents they are eligible for, including a birth certificate, Social Security card, health insurance ID card, driver's license, stated issued identification card, and a copy of the youth's medical records. 42 U.S.C. §§ 475(1)(C), 475(5)(D).

- Transition Plan

DCF must provide youth with a written transition plan that is directed by the youth and includes specific options for housing, health insurance, education, employment supports, and mentoring. The plan must be completed 90 days before the youth turns 18. 42 U.S.C. § 475(5)(H). A link to DCF's policy (No. 160) on transitional supports, which contains a copy of the transition plan is available here: https://dcf.vermont.gov/sites/dcf/files/FSD/Policies/160.pdf.

In addition to codifying the IV-E requirements, DCF's Family Services Policy No. 160, entitled *Supporting Adolescents in DCF Custody*, requires that DCF workers assist youth in re-applying for Medicaid, Social Security benefits (if eligible), promote "normalcy" activities[6] for youth in custody, assist youth in registering to vote and registering for the selective service, assist youth in obtaining a driver's license, refer youth to the Youth Development Program, and assist youth in securing mental health or developmental services through the Department of Mental Health (DMH) or the Department of Aging and Independent Living (DAIL).

Compliance with the above requirements is difficult to monitor, and the state lacks data on how often these requirements are followed. However, anecdotal evidence suggests that youth with special needs (i.e. for Supplemental Security Income or services through DMH or DAIL) are not always receiving the assistance necessary to continue receiving services beyond age 18.

In addition to the above-described requirements, youth have the option of signing an extended care agreement. Extended care agreements provide funding for youth who are engaged in 40 hours of productive activities per week, such as school or employment. State law requires that the DCF Commissioner "establish a program to provide a range of age-appropriate services for youth to ensure a successful transition to adulthood, including foster care and other services provided under this chapter to children as appropriate, housing assistance, transportation, case management services, assistance with obtaining and retaining health care coverage or employment, and other services." 33 V.S.A. § 4904(c). Under state law, DCF is required to inform youth of the existence of these services (and their right to receive them) and start creating a transition plan one year prior to the youth's 18th birthday.

The sheer volume of requirements, coupled with the differences between federal law, state law, and DCF policy make transition-planning a daunting task for DCF workers.

[6] Access to normalcy activities is a vital and often undervalued part of healthy adolescent development. The Preventing Sex Trafficking and Strengthening Families Act of 2015 (P.L. 113-183) requires that all children in DCF custody, including those in residential programs and group homes, have access to activities that promote normalcy. The Annie E. Casey Foundation defines normalcy in part, as being part of a supportive family, cultivating friendships with peers and having relationships with supportive adults, engaging in typical teenage activities and rites of passage (sports, school trips, driver's license, etc.), and having the authority to make their own decisions, try new things, and make mistakes. https://capacity.childwelfare.gov/states/focus-areas/foster-care-permanency/perspectives-normalcy

The high level of turnover within DCF, coupled with a decreasing number of adolescents in custody over the past decade likely contributes to a lack of awareness of the requirements on the part of individual DCF workers, as well as a lack of knowledge about how to accomplish all the required tasks on behalf of each youth. As much of the work falls on individual DCF workers, there may be significant variation in the quality of transition-planning even within the same office. As attorneys, we need to be aware of the importance of effective transition planning for our clients, and we need to be prepared to ensure that all clients have access to the transitional services they need to be successful.

So how can you ensure that your clients get the transitional services they are entitled to under law? First, ask your client what his or her goals are. As express-interest advocates, we must resist the temptation to push our values onto youth in custody. Though we likely mean well when we urge clients to pursue higher education or remain in a residential treatment program after the age of 18, failing to listen to a young person who is on the cusp of majority will almost always backfire. We need to ascertain our client's goals, and then work diligently to get them the supports and services they need to successfully pursue those goals. We must remember that clients who grow up in DCF custody have often had far less control over their lives than those of us who grew up living with our families. Youth who have felt disempowered, disrespected, and unheard throughout their adolescence do not respond well to perceived efforts to exert further control over their lives after they turn 18. It is our job to recognize this reality, try to mitigate it to the extent possible while the youth is in custody, and work to secure the benefits and services that the youth needs to be financially secure, regardless of whether the youth choses to extend his or her stay in placement.

Once you have ascertained your client's objectives, examine how existing services and supports can help your client meet basic needs while living in an arrangement that is consistent with the client's goals. Find out if your client is receiving SSI while in custody. If they are, ensure that DCF assists the client in reapplying for SSI benefits. Is your client receiving developmental services or mental health services? Depending on the severity of your client's disability, he or she may be eligible for services as an adult. Frequently, these services can facilitate independent living, which is often the goal of clients who have spent time in highly restrictive residential settings.

We must be especially attuned to the transition-planning needs of older youth who are currently living in residential placements. While youth in foster care often have the option of remaining in their current foster home after age 18, youth in residential programs may not be offered this same opportunity. Instead, the youth may be told that his or her only option is to remain in the residential treatment program. It is rare for youth to agree to such an arrangement, and instead, they often end up transitioning from the institutional setting to homelessness, shelter care, or an informal (and often, tenuous) living arrangement with friends or relatives. These youth are at very high risk for poor outcomes. If your client wants to return to foster care and reside with a family after age 18, you should file a written opposition to any permanency plan that calls for continued residential care and request a contested permanency hearing. By administrative rule, DCF can only fund residential treatment for a maximum of six

months after a youth's 18th birthday. Many courts are not aware of this fact, and may be surprised to learn that even if the youth does manage to stay in the program for six additional months, that youth will have no plan or means for support after age 18 ½. Point out that a similarly situated youth living in a foster home would have the option of remaining in that home until age 22. If your client prefers to live independently, examine whether the client is eligible for SSI (or other Social Security benefits), adult mental health or developmental services, or a Category C extended care agreement (through the Youth Development Program). If all else fails, connect your client with Spectrum Youth and Families Services or a similar youth shelter program, and ensure that DCF complies with all other required elements of transition planning.

All clients should have their transition plan reviewed by a court, but the timeframe for permanency hearings and the timeframe for developing the 90-day transition plan do not always line up. Talk to your client, the DCF worker and the GAL to review progress on transition planning regularly. It is also helpful to attend team meetings and case plan reviews *with* your older clients whenever possible so that you know what progress has or has not been made around transition planning and you can advocate for what your client wants a decisions are made. Additionally, it is useful to make a list of all of your 17-year old clients and to develop a practice of requesting a permanency hearing 90 days before the client turns 18. Contest permanency if DCF fails to provide an adequate transition plan and be prepared to demonstrate to the court the risk to your client should DCF fail to comply with the laws and policies described above.

Lastly, if DCF refuses to support your client in securing housing and an income or the court refuses your request for a permanency hearing, consider filing a motion for a protective order. The standard for a protective order is whether the conduct "is or may be harmful or detrimental to a child." 33 V.S.A. § 5115. This is a broad and flexible legal standard, and there is ample evidence of the harm inadequate transition planning causes.

Is Woodside Closing? The Future of "Secure Detention" in Vermont

Recent media coverage has focused extensively on continued problems with the use of force and other conditions of custody issues at Woodside.[7] Historically, Woodside has engaged in a number of coercive and traumatizing practices including use of excessive force, use of painful and dangerous restraint techniques, excessive use of seclusion, isolation from peers, and solitary confinement, forcible removal of clothing, failure to obtain necessary medical and mental health treatment for youth, and religious and racial discrimination.

[7] Alan J. Keyes, VT Digger, *As Woodside juvenile center is slated to close Oct. 1, second probe is underway*, (Aug. 23, 2020) https://vtdigger.org/2020/08/23/as-woodside-juvenile-center-is-slated-to-close-oct-1-second-probe-is-underway/; Alan J. Keyes, VT Digger, *Five Woodside workers suspended for 'unacceptable' restraint of youth*, (Aug. 7, 2020) https://vtdigger.org/2020/08/07/five-woodside-workers-suspended-for-unacceptable-restraint-of-youth/; Alan J. Keyes, VT Digger, *Group accuses state of breaking deal, not fixing 'dangerous conditions' at Woodside*, (Jul. 16, 2020) https://vtdigger.org/2020/07/16/group-accuses-state-of-breaking-deal-not-fixing-dangerous-conditions-at-woodside/

In August 2019, the United States District Court for the District of Vermont granted a preliminary injunction against DCF, requiring Woodside to adopt a new use-of-force system, prohibiting the facility from using long-term seclusion or isolation from peers to manage behavior, and requiring DCF to ensure that youth with mental health needs received appropriate treatment. DCF and the plaintiff, Disability Rights Vermont (DRVT), settled the case in April 2020. That settlement agreement: 1) limited the use of seclusion to no more than 3 hours; 2) affirmed the facility's transition from a dangerous use-of-force system developed by former Woodside Director Jay Simons to an evidence-based model of de-escalation and restraint; 3) required the facility to stop serving youth experiencing mental health crises; 4) required Woodside to hire a doctorate-level psychologist or a psychiatrist as director; 5) required Woodside renovate the segregation/isolation unit to convert it into therapeutic office spaces; and 6) required DCF to submit to a variety of monitoring and reporting requirements aimed at ensuring compliance with the terms of the settlement agreement.

Since the injunction, Woodside has had four different directors. Additionally, between March 2020 and May 2020, the Woodside program was moved to a new, non-secure location in St. Albans, a secure location in Middlesex, and back to the Woodside facility in Essex, Vermont. These changes, and the upheaval and discontent that accompanied them, likely contributed to the deterioration of conditions within the program.

On July 7, 2020, DRVT filed a motion for post-settlement relief alleging that DCF was violating the settlement agreement by continuing to use force in a harmful an unlawful manner. The filing described a June 29, 2020 restraint in which video "confirms that the same, or even more dangerous, pain-inflicting maneuvers that existed prior to this litigation were used again, despite this Court's Preliminary Injunction Order and Order approving the Settlement Agreement." The filing also described an incident in April 2020 where a staff member shoved a youth, resulting in the "youth's head striking the door with force."

On July 17, 2020, DCF Commissioner Sean Brown sent a memorandum to all Woodside staff and residents directing them to refrain from using seclusion for more than three hours at a time, refrain from calling law enforcement unnecessarily, refrain from using food as a reward or a punishment, use verbal de-escalation to avoid the need for restraint or seclusion, and to develop a program with clear expectations for youth behavior. The memo followed a visit by the Commissioner to the Woodside facility to address resident concerns.

On July 20, 2020, in its response to the DRVT filing, DCF represented to the federal court that it had arranged for a contractor to retrain all of the staff in the new restraint and de-escalation protocol known as Safe Crisis Management (SCM). DCF indicated that it had known of the need to retrain staff in SCM in April 2020 but that the retraining would not occur until July 20th and July 21st.

On August 6, 2020, DCF announced a renewed focus on closing Woodside. In a memorandum from DCF Commissioner Brown to the Joint Justice Oversight Committee, DCF announced that it had suspended new admissions to the Woodside facility and that just one youth remained in the facility. Commissioner Brown stated that DCF was actively seeking placement alternatives for the one remaining youth and

that DCF had already created a plan for the short-term care of youth requiring secure detention.

The reason for the suspension of new admissions became clear on August 28, 2020, when Commissioner Brown testified before the House Human Services Committee regarding closure of Woodside. In his testimony, Commissioner Brown indicated on June 29, 2020, a youth was restrained "incredibly inappropriately" and in a manner that "put that youth's health and safety at significant risk." He also testified that efforts to retrain Woodside staff in the proper techniques in mid-July had gone poorly. He cited instances of staff defending the former restraint modality, which he described as having "harmed kids and led to a federal lawsuit." The Commissioner explained that staff were "really resistant" to implementing the new, safer restraint and de-escalation modality and that this led to his conclusion that it was unsafe for State employees to continue providing secure detention services to youth. Commissioner Brown reported that as of Friday, August 28, 2020, the Woodside facility was empty. Several members of the House Human Services Committee expressed concern about DCF moving forward with plans to close and replace Woodside without legislative input. Deputy Defender General Marshall Pahl urged the committee to review Judge Crawford's order granting the preliminary injunction and emphasized that the decision to suspend Woodside admissions was made in response to an unsafe and untenable situation that had persisted for many years despite opportunities to change course.

Pending legislative approval, DCF plans to close Woodside for good on October 1, 2020, and the legislature is currently considering a bill that would close Woodside and require DCF to explore both private and public options for a smaller replacement facility. DCF is reportedly looking to shore up its system of care to serve youth in less-restrictive environments whenever possible. Additionally, DCF is currently placing youth who require secure detention overnight at the "Yellow House," a building owned by the Lamoille County Sheriff's Department and formerly used as a homeless shelter. According to Commissioner Brown, youth placed at the Yellow House are staffed by law enforcement and a DCF employee 24 hours per day.

DCF's long-term plan is to contract with a private entity, likely Becket, to create a 5-8 bed secure program in Vermont. Becket is a New Hampshire-based nonprofit providing residential and community-based services to youth. According to Commissioner Brown, the Becket program is unlikely to be up and running for at least twelve months. In the meantime, DCF hopes to contract with New Hampshire's Sununu Youth Services Center, a juvenile detention center, to house youth requiring secure detention. Unfortunately, conditions at Sununu are also highly questionable. The New Hampshire Attorney General's Office is investigating claims of sexual, physical and emotional abuse, and a class action lawsuit with over 100 plaintiffs alleges an ongoing pattern of abuse of residents by staff, including an incident of abuse occurring as recently as last year.[8] If you have a client who is facing detention at Sununu or another out-of-state detention center, please contact the Office of the

[8] Holly Ramer, the Associated Press, *Charges Dropped as Youth Center Abuse Investigation Widens*, (Mar. 11, 2020) https://www.fosters.com/news/20200311/charges-dropped-as-youth-center-abuse-investigation-widens

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