The Barahona Case

Findings and Recommendations

March 14, 2011

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Department of Children and Families

Governor Rick Scott

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EXECUTIVE SUMMARY

It is apparent that significant gaps and failure in common sense, critical thinking, ownership, follow-through and timely and accurate information sharing defined the care of Victor and Nubia Barahona from the very beginning of their relationship with our state child welfare system. This systematic failure includes the investigative and case management processes as well as the pre- and post-adoption processes. The collective wisdom of all professionals who played a role in making decisions about the physical and emotional wellbeing of Victor and Nubia never coalesced into an effective focus. Nubia Barahona was found dead in a truck parked off of I-95 in Palm Beach County on February 14, 2011 and her brother, Victor, was in critical condition. Both children had been exposed to inhumane treatment and their adoptive parents have been charged with Nubia's murder and multiple counts of aggravated child abuse and neglect as to both children.

An independent review panel, the Barahona Investigative Team, was appointed by Secretary David Wilkins to convene public hearings, conduct a critical analysis of case activities and develop preliminary recommendations for system improvement. The panel heard from 24 individuals including school officials, a foster parent, a Child Protection Team doctor, child advocates, lawyers who represent children and the department and provider agencies, as well as regional department staff and Our Kids CBC lead agency leadership and the public. A well-crafted articulation of findings and recommendations was issued by the panel on March 10th and is included as an attachment to this report.

Our recommendations are based on the findings and suggestions from the Barahona Investigation Team, a detailed analysis by Department staff which highlighted errors and omissions in adhering to statute, code and policy, and discussions with numerous stakeholders, government employees, elected officials and concerned citizens. In addition, the report contains a timeline of key events and a flowchart of Florida's child protection statutes. Additional supporting documents are available on the Department of Children and Families website: www.dcf.state.fl.us.

The following pages define our action plans and are organized in two areas: Those that can be acted upon immediately and initiatives that need long-term implementation. The immediate tasks are funded and have either already been initiated or are scheduled to be deployed in the coming weeks. Some of the long-term projects will require legislative approval. Not withstanding, the definition of the projects, requirements and scope determination will start immediately.

SUMMARY OF CASE HISTORY

Victor and Nubia Barahona first came to the attention of the Department of Children and Families four days after their birth. The twins, born May 26, 2000, went from the hospital to separate foster homes subsequent to a call to the Hotline. Born with a medical condition, Nubia required therapy and close monitoring; thus she was placed in a medical foster home. The biological mother, who suffered from a significant history of substance abuse, had her parental rights terminated as to the four other children. One child was adopted by a relative and the other three adopted by nonrelatives. Victor was reunited first with his biological mother and father on July 26, 2000 and Nubia was later reunited with her biological family on January 8, 2001.

The biological parents and children continued under court-ordered protective supervision by the Department for six months and the supervision was eventually closed on July 9, 2001.

On March 17, 2002, a call was made to the Hotline alleging that the children were exposed to domestic violence between the parents that led to the arrest of the biological mother. A child protective investigation verified that the children were at risk. The mother was arrested and no additional actions were taken nor were services provided. Because this particular investigation was not formally closed, it came under review approximately one year later as part of a "Backlog Reduction" Project. The new child protective investigator assigned to close out the case obtained information about the continuing medical needs of Nubia, made contact with the family in their home and filed a petition to place the children under shelter care status with custody given to their biological father due to the chronic substance abuse struggles of the biological mother. The courts terminated the parental rights of the biological mother on August 4, 2003, placed the children in the sole custody of the father, but allowed the mother to have visitation rights with Victor and Nubia under supervision of the biological father.

The Hotline next received a call on January 2, 2004 alleging that Victor and Nubia were at risk for abuse due to the biological mother's continued presence in their home. The allegations included references to the continued abuse of drugs by the mother, unexplained bruises on Victor and threats to Nubia's emotional well being. The investigation was subsequently closed with no indicators of abuse or neglect. According to casework notes, the biological father was referred to a Family Builders Program; however, records do not contain any information on the type of service or whether the family was connected to any assistance.

The biological father was arrested on March 26, 2004 and charged with sexual battery against a minor not related to him. This prompted a call to the Hotline and Victor and Nubia were placed in the custody of the state and moved to the foster home of Jorge and Carmen Barahona. Within four days of placement in foster care, contact was made with paternal relatives in Texas to explore their potential role as caregivers. A positive home study was ultimately received approximately one year and three months after the children were placed in the Barahona home. Despite this, professionals ultimately

determined that it would be detrimental to the well being of Victor and Nubia to be moved from the Barahona home due to the bonds created by the length of time the children had resided there.

In January 2005, the Hotline received a call alleging that Nubia had been sexually abused by her foster father. Nubia had recently undergone psychological testing and the CPI consulted with the evaluator about the allegations before interviewing Nubia. The evaluator stated that Nubia had disclosed fondling by the biological father and suggested that Nubia may be confusing the two father figures. The CPI consulted with the CBC case manager who had little concern about the Barahonas and didn't believe a change of placement was warranted. The case was ultimately closed as "with no indicators of abuse. The biological father was thereafter charged with sexual battery on the twins in April of 2005 and the court ordered him into treatment in November of that year.

Another year passed with Victor and Nubia in the Barahona foster home when the Hotline received a call prompting an investigation into allegations of physical abuse of Nubia. The report described bruising around the neck and chin area and references that Nubia had missed several days of school. The Child Protection Team saw Nubia and could not confirm abuse since Nubia's account of how she was hurt was determined to be consistent with the injuries. This February 2006 investigation was closed with no findings of physical abuse.

In February 2007, the Hotline accepted a call for investigation alleging that both children were coming to school unkempt. Nubia was described as always hungry and eating a lot of food at school. The CPI documentation reflected multiple concerns related to the children falling asleep in class and being frightened to go home at times. Both the CBC case manager and licensing staff were notified but no staffing was convened to develop a broader assessment as to the needs of the children and the Barahonas. The case was subsequently closed with no indicators of neglect.

Victor and Nubia's dependency case proceeded through the usual course of judicial reviews as the goal was changed from reunification with the biological father to adoption. The biological father's parental rights were terminated in May of 2007. When concerns were once again raised months later about the care of the children in the Barahona foster home, Nubia's pediatric endocrinologist submitted correspondence endorsing the Barahona's oversight of her medical needs. That year, both children struggled academically and were retained in first grade.

Once the appeals process for the termination of parental rights had been exhausted by the biological father, the children were legally free for adoption. Victor and Nubia's adoption by the Barahonas was finalized in May 2009 and one month later, the Barahonas submitted correspondence stating they would not renew their foster care license as their family was now complete.

Just over one year later, the Hotline accepted a call for a "Special Conditions" referral alleging that Nubia's hunger was uncontrollable and that she was suffering from hair

loss, weight loss and was unfocused and jittery at school. Mrs. Barahona attributed Nubia's condition to her hormonal issues. While collateral contact was made to confirm Nubia's scheduled surgery, Mrs. Barahona's statement about Nubia's medical care was not confirmed with her pediatrician or pediatric endocrinologist. The referral was closed with no services recommended. Subsequent to the closure of this referral, Victor and Nubia were voluntarily withdrawn from the public school system as the Barahonas intended to home school their children.

This case summary closes at the next series of events triggered by a call to the Hotline on February 10, 2011 alleging that Victor and Nubia are tied by their hands and feet and made to sit in a bathtub for extended hours. Four days after the initiation of a child protection investigation, Nubia is found deceased.

At the writing of this report, Victor continues to recover after being released from Jackson Memorial Hospital to a therapeutic foster home.

OBSERVATIONS AND FINDINGS

Victor and Nubia were known to the department shortly after their birth and had been the subject of investigations on two prior occasions before coming into care and subsequently being adopted by the Barahonas. This section focuses on investigative and case management practices from 2004 when the children were initially placed with the Barahonas through February 2011. The facts and observations are supported by detailed analysis conducted during the course of this review and revealed these overall shortcomings:

- Insufficient investigative practices characterized by superficial or minimal compliance with rules that were lacking analysis and critical thinking
- Inadequate case management practices focused on superficial observations regarding the twins' play and dress as opposed to ensuring the quality of their care and safety
- Rapid turnover, inexperience, excessive caseload and a lack of sufficient training for the CPI workforce
- Lack of integration of information sharing and communication among the many professionals who touched the lives of these children
- Unclear case ownership and case integration among various groups and unclear role of supervisors for both investigations and case management
- Insufficient attention to health care, mental health care, educational support and dental care which were clearly needed by the twins
- Failure to act in the face of significant evidence that the twins were receiving inadequate care in their foster home
- Conflicting professional opinions without any resolution
- Lack of post-adoption services for a family adopting three children with special needs
- Overall substandard quality of documentation by both case managers and protective investigators

OBSERVATION: Four days after the twins were placed with the Barahonas, it was learned that paternal relatives in Texas were interested in having the children placed with them. The approved Interstate Compact on the Placement of Children study was received June 29, 2005 – more than one year later.

Finding: The system needs to be able to connect children with relatives in a more timely fashion.

OBSERVATION: The Comprehensive Behavioral Health Evaluation provides a thoroughly researched assessment of:

- important facts about the early history of the twins prior to their entry into care
- their current physical/medical, social-emotional and developmental status
- how they were transitioning into the family life at the Barahona foster home
- early perspectives of the Barahonas as to care of these children

Finding: It appears there is no documentation or discussion of this specific comprehensive evaluation of the children's status when they came into the Barahona home, nor was it given to any future evaluator or future child protective investigator (CPI) or case manager to determine essential needs and interventions. If considered carefully it would have provided an excellent baseline that would have demonstrated that previously healthy and happy children were developing serious problems of fear of terrible things happening, thoughts of suicide, and depression while under the care of the Barahonas.

OBSERVATION: A nurse practitioner in the pediatric endocrinologist office expressed significant concerns about Nubia's medical care in the Barahona home indicating the adoptive mother was a very poor caretaker for not attending to the required medical care needed by the children.

Finding: There is no documentation of case management follow-up with the foster mother as to the concerns raised about Nubia's medical care. Indeed our study failed to find the required history of well child pediatric examinations and follow up care.

OBSERVATION: Case management documentation regarding Nubia's educational progress, school attendance, mental health services received, developmental status and medical and dental care is sorely lacking in the record.

Finding: This lack of documentation indicates that the various case managers did little to coordinate with the school, mental health community, and medical and dental community to ensure the children were receiving the care they needed. In general there was a disregard in the need to document and monitor Nubia's safety and wellbeing.

OBSERVATION: There is substantial evidence that both the CPI and case managers took a minimal compliance approach to Nubia. The goal appears to have been

completing checklist requirements over professional analysis and critical thinking to make sure that the twins were well cared for and safe.

Finding: The CPIs did not check Mrs. Barahona's explanation that Nubia's odors and unkemptness were a result of her medical condition. A simple medical understanding about Nubia's care would have dispelled what appears to be a myth created by Carmen Barahona. The CPIs lack of skepticism, analysis and use of necessary medical experts to get to the truth reflects a substantial failure of training and insight into the investigation process. Despite 48 visits with Nubia in the Barahona's home, the case management record reflects simple and repetitive comments about how she was playing and how she was dressed and generally fails to deal with the substantial issues of her developmental, medical, educational, dental, and mental well being.

OBSERVATION: A call was made to the Hotline alleging that Nubia was sexually abused by her foster father. The call was received late at night and the investigator consulted with the psychologist who had recently conducted an evaluation of both children. The evaluator questioned the veracity of the allegations and advised that delaying the interview of Nubia by one day would not be harmful. The investigator did not go to the home that evening to commence face-to-face contact with Nubia.

Finding: Documentation suggests the interview with Nubia was not adequate. In addition, interviews were not conducted with all household members that included other children that were placed in the foster home at the time. Case notes indicate the resolution of the report turned on different Spanish names which the children used for their biological father and foster father which was a inadequate basis to determine the report was unfounded. Neither the CPI nor the case manager interviewed the twins away from the Barahonas to get a more candid understanding of how they viewed their caretakers. This suggests that the importance of this fundamental responsibility is not well understood and may be due to inadequate training and professional insight for both the CPIs and the case managers.

OBSERVATION: A Hotline report was received in 2006 alleging bruises/welts on Nubia and the threat of physical injury to Victor. On the date of the report, Nubia was observed with a "large bruise extending down her chin and neck area". There were also concerns regarding Nubia missing several days from school.

Finding: Nubia's grades and attendance records were obtained and collateral contacts were made with the reporting party and school personnel by the CPI. There is no documentation that this information was conveyed to the case manager. Child Protection Team medical evaluation results and recommendations are not present in the file although it is indicated that the CPT was consulted. Documentation does not reflect how bruises on the back, chin and neck might have occurred as the result of a "fall" at school or at home. The record does not contain documentation to determine where the child sustained the injury but she returned to school with said bruises so it would seem to indicate the injuries did not occur while at school. There is no

documentation in case management records to reflect an awareness of any school difficulties with Victor or Nubia prior to this report and no documentation of ongoing follow-up concerning the children's educational needs. The fact of the additional injuries should have resulted in a finding of some indicators that may well have been verified with more analysis and professional help.

OBSERVATION: On three different occasions, the Citizen's Review Panel held a hearing and found there was no documentation of current physical, dental or vision check-ups available for the children, nor were they receiving required therapy.

Finding: Although three alerts were documented in court records about unmet medical needs for Victor and Nubia, there is no verification that this information was acted upon. In addition, there is no information on the status of pediatric endocrinology monitoring of Nubia. It appears the recommendations of the Citizens Review Board were not acted upon.

OBSERVATION: The Hotline referred a case for investigation alleging environmental hazards to both children, as well as two adopted children residing in the home. It was alleged that Nubia had an unpleasant body odor and that both she and Victor appeared unkempt for the past five months. Documentation reflects multiple concerns related to the children falling asleep in class and being scared to go home at times. This investigation was closed with no indicators of abuse on April 12, 2007.

Finding: There should have been a staffing with all parties to develop an integrated assessment of the children's needs and the quality of care being provided by the caregivers including the use of corporal punishment by the caregivers (beating on the bottoms of Nubia's feet), excessive school absences, falling asleep in class, Nubia's hoarding of food and her fear of going home. School staff indicated Nubia appeared to feel threatened by the foster mother, yet no additional interview was conducted at a separate and/or more secure location for Nubia outside the presence of the caregiver. Documentation does not reflect that the CPI attempted or established contact with the children's Guardian Ad Litem. These were compelling facts gathered by the CPI that should have resulted in "some indicators" or "verified" findings for abuse.

OBSERVATION: A psychological evaluation was completed in June of 2007 that raised concerns about the emotional health of Nubia and recommended individual therapy for each child.

Finding: There were serious symptoms of depression and thoughts of suicide evident that did not result in therapy as recommended. Most striking is Nubia's premonition that something terrible was going to happen to her.

OBSERVATION: The court ordered psychological and psycho-educational evaluations on August 3, 2007.

Finding: A psychological evaluation for both children had just been completed on June 5, 2007 that was not brought to the court's attention until October 19, 2007.

OBSERVATION: The Guardian ad Litem was barred from the Barahonas home due to inquires made with the school. The case manager documented that at one visit no one answered the door even though voices could be heard inside the home. During another home visit the case manager was told that Nubia was at day care; however, Nubia was not found there when the case manager followed up that day.

Finding: There was no assessment made of the lack of access to Nubia by the Guardian ad Litem. The Guardian ad Litem was discharged from the case to smooth over relationships with the Barahonas. The case manager never documented concerns over the apparent deceptions as to Nubia's whereabouts or made any attempt resolve the discrepancies in information.

OBSERVATION: The paternal relatives in Texas continued to attempt to make contact with the case managers and engage in the court process with expressed interest in providing a permanent home for Victor and Nubia.

Finding: The length of time that Victor and Nubia had been in the care of the Barahonas effectively dismissed the possibility of considering a relative placement (or any other placement) for the children. This was based on an incorrect assumption by all professionals involved in the case that it would be harmful for children of this age to experience a change in parents.

OBSERVATION: The Hotline received a report in June 2010 alleging that Nubia's hunger was uncontrollable; she was very thin, unfocused, jittery, and unclean and had missed two weeks of school. The call was accepted as a "Special Conditions" referral and a child protective investigation was not commenced, rather a Parent Needing Assistance services response was commenced.

Finding: The reporter provided sufficient information to the Hotline counselor to prompt a protective investigation rather than a Parent Needing Assistance response. Nubia was not seen until eight days after receipt of the call to the Hotline. Although the CPI confirmed a scheduled surgical appointment for Nubia, collateral contacts were not made with Nubia's pediatrician or endocrinologist about her ongoing medical care.

OBSERVATION: No post-adoption services were offered or provided to the Barahonas in spite of the fact that three of their four adopted children had special needs.
Finding: It is unclear whether Our Kids developed a clear, easily accessible outreach practice of providing post-adoption services. This is especially important for adoptive parents of special needs children who will face significant stressors and challenges and who may lack the specific information to address complex medical, developmental, and educational problems that emerge and evolve as children grow. There is no evidence uncovered that the Barahonas received any special support or training in the raising of

children with complex medical, educational and developmental problems after the adoption.

OBSERVATION: A review of the Hotline call on one allegation demonstrated that although the counselor obtained detailed information from the reporter about threatened harm to a child, it was not all communicated to the field.

Finding: It appears that Hotline counselors were feeling pressure to complete the call without ensuring that the reporter felt they had an opportunity to state all facts known to them about the concerns and the safety of a child.

OBSERVATION: The Hotline call received on February 10, 2011 contained allegations that suggested criminal child abuse incidents requiring immediate response and outreach to law enforcement.

Finding: Although the CPI was unable to make face-to-face contact with the children when the investigation was initiated, the CPI proceeded to classify Victor and Nubia at "low risk" of abuse and did not engage supervisory consultation or seek assistance from law enforcement.

OBSERVATION: For the most recent call to the Hotline, two separate investigations were created by counselors for the same case and transmitted to the field. This resulted in the assignment of two separate CPIs on the same case without their knowledge.

Finding: Failure to properly link cases at the Hotline prior to sending to the field for response creates a duplication of work effort and inefficiencies in limited manpower in the field to manage investigations.

RECOMMENDATIONS

Short Term Actions

Law Enforcement Integration

1. Last week, the department implemented a new protocol with the Miami-Dade Police Department to ensure immediate notification for abuse and neglect and missing children and make police assistance available immediately when needed by CPIs. We are grateful for the police department's decision to increase their staffing so we may achieve the following:

    - All child abuse investigations coded for response within two hours will be forwarded electronically upon receipt to all law enforcement point of contacts immediately.

    - All investigations requiring response within 24 hours will be organized by jurisdiction and electronically transmitted to law enforcement twice daily.

A police notification coversheet for each jurisdiction has been created to list all investigations assigned to each jurisdiction. The information captured on the coversheet identifies the intake number, name of supervisor and a comment section. The comment section allows law enforcement to indicate the action taken by their agency and subsequently returned to the department electronically with comments and/or copies of the police reports, where applicable. This information is forwarded to the units for appropriate distribution to the supervisory and investigative staff.

In addition, several protective investigators and a supervisor have been placed with the Miami Dade Policy Department's Domestic Violence/Missing Persons Unit. This will result in the ability to react quickly to cases involving egregious behavior that require a joint law enforcement / CPI response. In addition to the collaboration with the Miami Dade Police Department, staff is working with all the law enforcement jurisdictions to review working agreements.

2. Review the law enforcement protocols in each circuit across the state and make sure that each includes immediate notification of law enforcement when the abuse and neglect is a crime. This review has begun and will be completed in each circuit within two weeks.

Hotline

3. Meet with Hotline supervisors and staff beginning this week to direct and clarify expectations on the following:

    a. Confirm that Hotline counselors know how to identify calls requiring immediate investigative response and develop protocols to implement such assurances.

    b. Improve the quality of customer service by real-time monitoring of counselor interaction with individuals who call the Hotline.

4. Establish a new procedure that results in the urgent handling of calls to the Hotline made by school personnel effective immediately. This will be completed in the next week and then communicated to all schools.

5. Immediately eliminate all incentive and measurement of Hotline performance related to the length of time a counselor spends on a call to develop their narrative and determine an appropriate response. Emphasize quality over speed.

6. Review Hotline personnel records commencing this week and determine if additional performance improvement plans are needed for individual counselors. Assess employees currently under corrective action plans for adequacy of the plan and progress being made by the employees to improve performance. Take personnel action as needed.

7. Review workload and supervisory/staff ratios and adjust accordingly to remedy unbalanced staffing for peak hour of calls to the Hotline.

Child Protective Investigations (CPI)

8. Require management meetings to be held with each CPI statewide to ensure that all understand the expectations of child protection including immediate response, prompt notification of law enforcement, diligent search for missing children, interviewing each child in a safe place, making key collateral contacts, mandatory referrals to the Child Protection Team, trauma-sensitive transitions, etc. These meetings have already commenced and will be completed in the coming weeks.

9. Assess CPIs currently under corrective action plans for adequacy of the plan and progress being made by the employees to improve performance. Take personnel action as needed.

10. Launch supplemental training for CPIs to improve skills for investigatory interviews of children and the effective development and presentation of

evidence in court. This training program is under development and delivery will commence in the next 30 days.

Community-Based Care (CBC)

11. Direct CBCs to review all foster children in the coming weeks to verify they are receiving required child health, vision and dental examinations as well as follow-up health care. This review needs to identify their major shortcomings and action plans to get these children back to acceptable standards of care. The ongoing status of medical / health care is required to be documented in the statewide automated system of record, the Florida Safe Families Network (FSFN).

12. Require CBCs to collaborate with the department to convene Educational Summits in each circuit before the end of this school year and develop an action plan ensuring that each child receives necessary education support and plan for the capacity to electronically transmit school records to CBC's when possible. This includes information related to children who experience a change in educational settings. The ongoing status of a child's educational progress is required to be documented in FSFN.

13. Report to the Secretary all current post-adoption supports/services for families offered by the CBCs. The report must include a description of the resources offered and the mechanisms in place to ensure that every adoptive parent is fully aware of these services and knows how to access them. This should also include a description about services offered in support of children with special developmental, educational and medical needs and any follow up for services offered when children experience a change in educational settings. This report is due within 30 days.

14. Require the CBCs to convene meetings with each case management organization within 30 days to ensure they fully understand case ownership responsibility as the integrator of all services and supports identified for each child, including therapy, other mental health services, health and dentistry, developmental services, educational support, permanency and safety; as well as their responsibility to make trauma sensitive transitions when it is determined that a caretaker lacks the needed level of responsibility to care for their children.

15. Investigate the expert witness selection process with Children's Legal Services and report to the Secretary on recommendations related to the identification, selection and retention of expert witnesses.

16. Mandate the establishment of an integrated review team in every region that includes the CPI, the case manager, licensing, subject matter experts and leadership to review and determine a plan of action for reports of abuse or neglect in foster homes. This review team will be led by the CBC organization

responsible for each report and will understand that a pattern of unfounded reports deserves as close attention as those with verified findings. We will ask for each CBC to have this process in place in the next month.

Management

17. Immediately begin modification of FSFN computer software to establish an automated notification process to local CBCs whenever abuse or neglect reports are received on foster or adoptive parents.

18. Finalize plans that will authorize CPIs and case managers to scan documents into FSFN for the establishment of the single official record for every child.

19. Review all performance metrics used with DCF staff and CBCs and eliminate incentives that give greater weight to compliance-oriented measures than those which emphasize quality and proper care of children and services to families.

Long Term Projects

Child Protective Investigations

1. Immediately begin the recruitment of an additional 80 CPI employees for he Southern, Northeast and Southeast Regions. This will reduce the average caseload in these regions from 16:1 to 14:1 once fully deployed. In addition, we will significantly reduce pre-service orientation by streamlining processes and combining field-based training requirements. These positions will be fully funded and the goal is to have CPIs active in the field within 60 days.

2. Re-engineer child protective investigations processes, including recruitment, training, technology empowerment, collaboration with CBCs, law enforcement, schools, the medical community and other professions relied upon to ensure the integrity of the investigative function. This project will address both the CPI duties conducted by the sheriff's offices as well as the department in-house services. Phase 1 will determine the scope and define the requirements of the responsibility. It will also establish the leadership and governance of the project. Phase 1 will be completed in three months. Phase 2 will focus on the design of the requirements and establish implementation alternatives and cost estimates. It is expected to be a very collaborative process seeking input from all stakeholders and should be completed in time to submit a budget request for the 2012 legislative session.

Hotline

3. Redesign the state central Hotline organization to include integrated web based reporting tools, a new state-of-the-art Integrated Voice Response technology and

a new organizational operations model. This will address the recruitment, training and ongoing professional development of counselors and supervisors. Phase 1 of this project will be completed within three months and will include the overall design and implementation plan. Phase 2 will commence immediately after Phase 1 and Phase 3 will be the implementation and is expected to be completed in one year.

Community-Based Care

4. Require the development of an action plan by Our Kids, the CBC in the 11th circuit, to address and correct findings identified by the external investigative review panel; including how and when actions will be implemented. This plan will be submitted to the department within two weeks. Upon completion of a mutually agreed upon Corrective Action Plan between the department and Our Kids, a Peer Review will be formed to assess the quality of Our Kids case management services. This Peer Review will be conducted by representatives from other CBC organizations across the state as selected by the Secretary. It is expected that this will be completed in 30 days from the date commenced and will include a report to the Secretary on findings and recommendations.

5. Launch a project to design an integrated case management and alert notification system for all CBCs across the state. This project will create the capability to assist caseworkers with the management of the cases by providing caseload and supervisor functionality. This will also include automated alert functions for missing information, new event determination and risk scenario identification. As part of this project, Structured Decision-Making will be examined and its applicability for statewide roll out and integration with existing case assessment instruments will be determined.

   This overall capability will be centralized with existing technologies and processes occurring in the CBC's and state office today and it will drive significant process improvement in case management to ensure pro-activity is embedded in case management. Phase 1 will be completed in six months at which time the scope, responsibility and requirements of the project will be established by the leadership and governance team selected by the Secretary. Phase 2 will begin immediately after completion of Phase 1.

Under the direction of Secretary David Wilkins, Ramin Kouzehkanani has been appointed to oversee the implementation of the above short and long term recommendations. Mr. Kouzehkanani will be assigned to this role full time. As indicated above several times, we will establish a project advisory team and project steering committee for each of the major projects. The participant of each committee will include key stakeholders from the department, sister agencies and our CBC partners and provider communities.

This will ensure the people of this state, the key business partners and advocates of our child care systems and our governmental and elected officials all have a voice in improving Florida's child welfare system to help ensure that nothing like this ever happens again.

Attachments:

1. **Barahona Investigative Team Report**
2. **Child Welfare System – Child Protection Statute Flow Chart**
3. **Barahona Case Time Line**

BARAHONA INVESTIGATIVE TEAM REPORT

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Preface

The image of Nubia - golden hair and smile framed by pony tails, sitting up straight and facing the future - is with us forever. Hers is the very picture of life and childhood in bloom - green eyes and good heart eager for what life might bring.

Nubia never had the life she wanted, the life she deserved. Her life was short. Not even 11 years. Full of horror, ending in horror. Her final screams and cries cannot leave us, should not leave us.

We do not want to call her "Nubia Barahona" because she didn't deserve to have that last name. So we will not. Just "Nubia."

All children begin with innocence. No child deserves to have innocence taken. Nubia's was ripped away. That makes us weep. And angry.

When terrible things happen, we are obliged as people to learn lessons - and apply those lessons. Shame on us - all of us in Florida - if we cannot learn from this so other children have a far less chance to have such horrors visited upon them.

The courts will decide the fate of those charged criminally in this case. The rest of us - you, us, all of us -- have much else to do. We three citizens of Florida went through more than 15 hours of testimony and several thousand pages of documents, and see so clearly this:

The red flag of caution and warning was raised many times: By teachers and principals, by a Guardian Ad Litem (GAL) and her attorney, by a nurse, by a psychologist, by Nubia's "family" stonewalling the search for fundamental information.

But nobody seemingly put it all together.

We do not seek to condemn all the people of the Department of Children and Families (DCF) nor all the people of Our Kids (the community-based care oversight group and its subcontractor agencies). We are sure that many of them are good and caring and skillful professionals who work to preserve to keep families together when they should be together, and work hard to do right by each and every child. We also know that some of them are substantially undercompensated for what is frequently the toughest sort of challenges. But none of us should be permitted to use those sorts of things as an "excuse," or say, or think, "mistakes happen." Though surely they do, mistakes must be seen as inexcusable when they involve human life, most especially the lives of the most vulnerable.

In Florida we talk about a "system," but we are far from a real "system." We would be much closer to a genuine system if the operating principle in the case of every child in the child welfare system was this: We will insist that every piece of relevant information to a child's life and future is available in one, constantly updated place where everyone

responsible for that child's well-being could see that information, discuss it, assess it. And we will apply critical thinking and common sense -- always. None of this happened here. For these and other reasons, Nubia died. Horribly.

We do not seek a bigger bureaucracy. Over the years process upon process, bureaucracy upon bureaucracy, have been added to the workload of case managers and child protective investigators and others who work in the field of child welfare. Indeed, steps should be taken to minimize "process" and "bureaucracy," substituting such with making sure we have employed and trained and advanced and compensated fairly the best, most skilled, most caring professionals - and then demanded from each not only those skills, but a great heart and real common sense. Speaking to common sense and effective listening, who within the system worked effectively to hear what Nubia and Victor were trying to say? That sort of listening requires healthy skepticism on everyone's part - the protective investigator, the case manager, the Guardian Ad Litem, Children's Legal Services, the court, the therapists. Remember that so much about the narrative was woven and manipulated by Mrs. Barahona. Moreover, it seems to us, case managers and child protective investigators seemed often - and it turns out - wrongly enthralled by the psychological report. The report, as Dr. Walter Lambert so clearly testified, was patently incorrect. In fact, children have considerable resilience at the age of these children to go through planned and trauma-sensitive transitions. Thus, a conclusion that a change in foster parents would destroy them is absurd.

What we heard makes clear that everyone seemed to be relying on professionals who were either unaware of all the research in trauma-sensitive transitions or not making an effective analysis of the information available because, among other things, professionals were not listening to, or taking into account seriously enough, what the children were saying. In Nubia's case this included well-documented depression and fear that something terrible was going to happen to her. (And it did.) As parents we know if we had heard this about our own children, we would have searched - immediately and relentlessly - for the roots of this fear and depression and wouldn't have accepted a simple referral to a therapist as an answer anywhere near complete.

Unlike previous blue-ribbon panels following the deaths of Rilya Wilson and Gabriel Myers - upon which two of us have served - we have sought, at the direction of the new secretary of DCF, recommendations arrived at more quickly so they can be implemented as immediately as practicable. We give you, then, recommendations along two paths:

One: Recommendations that can be addressed and applied within the next 90 days.

Two: Recommendations that will require exploration, take longer and may well involve legislative and gubernatorial action and leadership.

In the name of Nubia, and all the children of our state, we thank you for the privilege of service.

David Lawrence Jr. Roberto Martínez Dr. James Sewell

Introduction

On Feb. 14, 2011, 10-year-old Victor Barahona and his adoptive father, Jorge Barahona, were discovered next to their family vehicle on the side of Interstate 95 in Palm Beach County. Responding law enforcement personnel determined both Victor and his father were in dire need of emergency medical assistance; officials also detected toxic fumes emanating from the vehicle. Both father and son were suffering from what appeared to be chemical burns to their bodies. After Victor and his father were hospitalized, the body of Victor's twin sister, Nubia, was discovered in the trunk of the vehicle.

On Feb. 15, the Miami-Dade Police Department notified DCF that the father had confessed to causing Nubia's death, reporting that he and the mother allowed the child to starve to death. The father told police he also had planned to kill his adopted son and commit suicide, but had failed to follow through successfully. Both parents have been charged with first degree murder.

The Barahonas' other two adopted children were taken into protective custody and placed in a therapeutic foster home.

At the time of Nubia's death, the department had an open investigation on the family due to allegations of bizarre punishment and physical injury.

Independent Investigative Panel

As a result of the issues in this case, on Feb. 21, DCF Secretary David E. Wilkins established an independent investigative panel to examine this case and other issues involving the Barahona family. Specifically, the charge to the panel was two-fold:

- First, to determine what went "wrong" and what went "right," and make recommendations that can be achieved within the next 90 days;
- Second, to identify other issues and practices that the department and its contract providers must review in depth over the coming months and which ultimately may involve changes in law or policy, as well as in child welfare practices.

Secretary Wilkins asked three individuals to serve as members of this panel:

- David Lawrence, Jr., president of The Early Childhood Initiative Foundation and chair of The Children's Movement of Florida.
- Roberto Martínez, Esq., former U.S. Attorney for the Southern District of Florida and currently a member of the State Board of Education.
- James D. Sewell, Ph. D., retired Assistant Commissioner of the Florida Department of Law Enforcement.

In preparing its findings and developing its recommendations, the panel held five public meetings at the Rohde State Office Building in Miami:

- Feb. 25
- March 1
- March 3
- March 7
- March 10

The panel heard presentations and testimony from 24 individuals who were invited or requested the opportunity to speak; a number of these appeared several times before the panel.

In addition to these presentations, members of the panel reviewed myriad materials, including studies, reports, previous investigations, statutes, operating procedures and model policies related to the Barahona case. At the written request of State Attorney Michael F. McAuliffe, and so as not to jeopardize the active criminal investigation, the panel focused its review on material and information received prior to the onset of the criminal investigation that began Feb. 14. Copies of all material provided and PowerPoint presentations made to the panel are maintained on the website created to ensure the transparency of this process (www.dcf.state.fl.us/).

Findings

(1) The court-ordered psychological evaluation of Nubia and Victor performed on Feb. 12, 2008 by Dr. Vanessa Archer recommending adoption of Nubia and Victor by the Barahonas to be "clearly in their best interest" and "to proceed with no further delay" --- failed to consider critical information presented by the children's principal and school professionals about potential signs of abuse and neglect by the Barahonas. That omission made Dr. Archer's report, at best, incomplete, and should have brought into serious question the reliability of her recommendation of adoption. Several professionals, including the Our Kids' case manager, the GAL, and the Children's Legal Services attorney, as well as the judge, were, or should have been, aware of that significant omission, and yet apparently failed to take any steps to rectify that critical flaw in her report.

(2) There appears to have been no centralized system to ensure that critical information (e.g., the schools' concerns, the children's academic troubles, and the reasons for the court-ordered evaluation) was disseminated to and examined by the psychologist, or that participants informed about the particulars of the case (e.g., the case manager, the DCF attorney, the GAL and the GAL attorney) followed through in reviewing the evaluation. In September 2007, a School Multidisciplinary Treatment Team found that Victor was demonstrating poor academic progress and would be repeating first grade; yet, in a report to the court on Feb. 22, 2008, Dr. Archer says, "while both children are in special educational classes, they are excelling

academically." Information about the children's academic performance is readily available online from the Miami-Dade Public School System and could have been accessible by the psychologist if she had been authorized to use the children's parent portal. It should be noted that the panel was provided an administrative law judge's opinion in another case in which Dr. Archer's "acquisition of her entire factual basis for her testimony commenced 10 minutes prior to entering the hearing room. At that time, she reviewed medical notes, consulted with [department counsel] and met with the child and the foster mother, briefly." The Administrative Law Judge on that case referred to this as a "drive-by diagnosis."

(3) The delay of more than five months to perform the psychological evaluation ordered by Judge Valerie Manno-Schurr appears inexcusable in light of the fact that it was compelled by the very serious concerns raised by the principal and teacher at the children's schools about the safety of Nubia and Victor in their foster home. In total, about 11 months lapsed between the date the GAL attorney and the Abuse Hotline received the concerns from Nubia's school on March 20, 2007 and the date Dr. Archer's report was filed with the court on Feb. 22, 2008.

(4) While this case was complex there were throughout a number of visible, but neither comprehensively nor effectively handled, red flags that should have resulted in further review. Throughout the life of the case, the GAL, school personnel, and a nurse practitioner raised concerns that should have required intense and coordinated follow-up. The troubling nature of these flags, were largely ignored. Behavioral concerns and difficulties in school performance also should have generated a more integrated response in which the concerns of all parties could have been considered and reconciled.

(5) This case spanned a number of years and a large number of reports. Significantly, much of the documentation was incomplete or inadequate, and it was difficult for this panel, as well as staff concerned with quality assurance, to reconstruct what actually occurred, who was or should have been involved, and the results of any action taken. This is at best sloppy note-taking.

(6) Process can give a false sense of complacency to those involved in the system. Simply checking off a box on a standardized form, observing children during a brief visit, or conducting a pro forma evaluation without considering all the issues that impact a child do not eliminate the need for reasoned judgment. Critical thinking, common sense and a sense of urgency were lacking at points throughout the life of this case.

(7) As we have seen in other cases in the past, no one accepted the role of "system integrator" with responsibility to ensure that each individual involved shared and had access to all pertinent case-related information, including allegations of abuse. That point person needs to be the case manager who ensures that all of the information is blended into a useable format. As in other cases, the Our Kids case manager, GAL, GAL attorney, DCF Children's Legal

Services attorney, and psychologist each had specific responsibilities. But no single person came to the fore and said, “I am responsible.” We cannot let that happen again.

(8) The school system served as an independent barometer of issues occurring in the lives of Nubia and Victor, and both kindergarten and elementary school personnel were willing to be involved in raising the issues in an appropriate forum, including testifying in court hearings. These school personnel deserve to be commended for their diligence as caring professionals. After the end of the 2009-2010 school year, the Barahonas chose to home school the children, taking away most of their visibility to outside eyes and increasing the danger that abuse and neglect would go unrecognized. This was further compounded by the lack of formal requirements relating to the monitoring of students being home schooled.

(9) DCF and Our Kids discussed with the panel a number of new practices that have been implemented since these children were first put into foster care and that should reduce some of the concerns we saw in this case. The model of Structured Decision Making (SDM), used in Miami-Dade County by both child protective investigators and case managers, appears to offer an organized approach to assessing safety, risks, potential future harm, and the needs of the family <u>but only if correctly and consistently applied</u> and takes into account all known facts and circumstances. Enhanced use of technology could reduce some of the paperwork burden of the investigators and case managers and ensure better and more real-time communication among the elements of the child welfare system. <u>But technology should never substitute for the exercise of critical thinking, sound judgment and common sense.</u> Technology should be used to augment and enhance those skills.

(10) While Our Kids has discussed expanded post-adoption services now available in Miami-Dade County, the panel cannot emphasize more strongly the necessity to ensure that adoptive parents understand the resources that are available. That alone may not suffice. Appropriate follow-up by the case management agency must support the use of such services to meet the family’s unique needs.

(11) Early in this case, the biological father suggested that a family placement with his sister and brother-in-law was more appropriate than with foster parents. Delays in using the Interstate Compact on Placement of Children to accomplish this and the opinion by Dr. Archer that removal from the Barahona family would be detrimental to the children resulted in this not being considered a viable option.

(12) Throughout the case, there is evidence that the Barahonas did not ensure the mental and medical health of these children. On several occasions in the file, Victor’s dental needs are noted, and, as early as December 2004, a nurse practitioner noted concerns about both Nubia missing appointments and the failure of the foster mother to accompany her to appointments she did keep.

On Aug. 8, 2008, the Foster Care Review Panel expressed concerns that Nubia had not received therapy, noted that this panel had recommended such therapy at a previous meeting, and that an earlier evaluation had found Nubia to be depressed, thinking about killing herself, and afraid that terrible things might happen to her. The case record for Nubia provided to the panel by Our Kids contains scant documentation about health care services received.

(13) The panel is extremely concerned about the accountability of DCF child protective investigators for their on-the-job performance. Data provided to the panel indicated that of 58 investigators evaluated during the last annual performance appraisal period, five had less than satisfactory performance evaluations (three of whom were supervised by a supervisor on a corrective action plan for poor performance). One of these was placed upon a performance improvement plan; one was transferred to another unit; one demonstrated improvement and is being re-appraised; and two had no action taken. The child protective investigator responding to one of the abuse reports of Feb. 10 was one of the employees who had received a less than satisfactory annual rating. (Currently, three CPI supervisors also are on corrective action plans for job performance.)

(14) We appreciate the openness of discussions by the majority of those who appeared before the panel. Honesty, candor and transparency are critical to the continued improvement of our child welfare system. However, we must note that the presentation by Delores Dunn, the CEO of the Center for Family and Child Enrichment (CFCE), the case management organization contracted by Our Kids for Nubia and other foster children, was unsatisfactory. In her prepared comments, she repeatedly failed to demonstrate a grasp of the basic facts surrounding the work of her case managers. Her “stage handling” by Fran Allegra, CEO of Our Kids, Inc. and Alan Mishael, Counsel retained by CFCE created suspicions as to what, if anything, they were trying to hide, with both of them answering for her or whispering in her ear while the panel was posing questions. None of this contributed to the candid discussion we expected; instead, it resembled the “circling of the wagons” seen in some past reviews of cases occurring within Florida’s child welfare system.

(15) On June 9, 2010, the Abuse Hotline received a call from Nubia’s school detailing comprehensive allegations of explicit neglect, including that Nubia’s hunger was “uncontrollable, that she had an unpleasant body odor, and that she was very thin, nervous, and losing hair.” The report was assessed as a “special conditions” referral, indicating that it did not constitute an allegation of abuse, abandonment, or neglect, but still required a response by DCF to assess the need for services. That report was closed on June 24 with no services recommended. The parents apparently were offered services, but said they were already receiving what they needed. Based on our review of the entire series of cases involving Nubia, the panel finds that the allegations should have been treated as a case involving abuse or neglect and that Our Kids should have been involved in identifying and providing post-adoption services. This was the last call to the Abuse Hotline from the school system.

The children were removed by the Barahonas from the school system for the 2010-2011 school year and presumably "home schooled."

(16) The response to a Feb. 10, 2011 call and two subsequent calls to the Abuse Hotline concerning abuse of Nubia by the Barahonas was replete with errors and poor practices and stands out as a model of fatal ineptitude. Abuse Hotline personnel initially classified the call as needing a response by investigators within 24 hours, when it should have mandated an immediate response and a referral to law enforcement; another call received on Feb. 12 also was misclassified as needing a response within 24 hours response when it, too, should have required the immediate attention of an investigator. Three calls received within 48 hours about the Barahonas were considered wrongly -- and stupidly -- as three distinct events, and the investigative responses were not coordinated from the onset. The SDM instrument developed after the initial on-site review of the Barahona home was completed incorrectly and did not take into account the absence of Nubia or Victor or their potential danger; consequently, the investigator found no concerns for the safety of the other children in the home. An initial supervisory review completed late on Feb. 12 was conducted by a supervisor, did not take into account all the facts of the case, and failed to identify investigative deficiencies or add a sense of urgency to the activities of the child protective investigator. At no time prior to Feb. 14 was law enforcement advised of these abuse allegations or DCF's inability to locate the children.

(17) The panel is concerned about efforts to recruit, train, reward and retain child protective investigators. The starting salary for a DCF child protective investigator in Miami-Dade County is $34,689. Comparable salaries are in the $40,000 range for Broward CPIs, located under the Broward County Sheriff's Office, and Miami- Dade case managers working for Our Kids. In short, many top performers leave this stressful job and are paid more money in the process. Thirty-nine investigators have been hired since July 2010, with 10 of these still in training and not yet with a caseload. An additional eight vacancies currently exist, and three more are anticipated in the near future.

(18) Foster Care Review, a not-for-profit organization, supports the Juvenile Court in monitoring the safety, well-being and permanency of children living in the child welfare system in Miami-Dade County. Its volunteers serve on citizen review panels that conduct legally required judicial reviews of 13-15% of foster children in out-of-home care. Nubia's case was presented to a citizen review panel on eight separate occasions over the last three years she was in the foster care system, prior to her adoption by the Barahonas. We were impressed with the Foster Care Review potential and would hope it would be expanded and used in many more cases.

(19) In 1993, the Legislature authorized the then Department of Health and Rehabilitative Services to enter into agreements with sheriffs' offices or police departments to assume the lead role in conducting criminal investigation of child maltreatment, as well as other aspects of child protective investigations.

In 1997, the Manatee County Sheriff's Office was the first to assume contracted responsibility for child protection investigations. Since then, seven county sheriff's offices have assumed responsibility for child abuse investigations in their jurisdiction. According to a 2010 report by the Office of Program Policy Analysis and Government Accountability (OPPAGA), the costs for a sheriff's office generally exceed DCF costs for child protective investigations. But there are significant benefits, including enhanced resources, additional equipment (including vehicles and technology), enhanced entry-level training, better training consistent with law enforcement needs, standardized uniforms, better office space, better salaries, and greater assistance and cooperation with law enforcement. (This same OPPAGA report found no meaningful differences between sheriffs' offices and DCF in short-term outcomes for children as measured by subsequent maltreatment within three to six months when an investigator did not originally substantiate maltreatment, nor were there significant differences in the rate of substantiation of allegations of maltreatment between the two bodies.)

(20) Much of the necessary information raising red flags and identifying the service needs of the Barahonas was present in documents contained within the system. A serious deficiency, however, was the failure of individuals involved in the case to talk with each other rather than relying on inadequate information technology. Many of the communications problems that can be identified in this and other cases can be overcome by prompt and coordinated interpersonal interaction among those involved in the care of the child. <u>We emphasize: There is no substitute for critical thinking and common sense.</u>

Short-term Recommendations (Within 60-90 Days)

Quality of Case Managers

Case managers are central to the well-being of the children in the system. It is critically important that they be qualified, well trained, well supervised and fairly compensated. DCF immediately should undertake a comprehensive review of the quality of the work performed by the CFCE and its case managers, including the quality of the oversight of CFCE provided by Our Kids. The defensive presentation by CFCE, with its denial of mistakes, even with the benefit of a hindsight review, throws into question the level of its professional standards and its ability to monitor the quality of its professionals.

Psychologists

1. DCF should commence an immediate review of the work and qualifications of the psychologists used by the court system. This review should by performed by a panel of psychologists independent of the Miami-Dade children welfare system and should include recommendations to improve the quality of the professionals and of the system.

2. Children's Legal Services should work with the chief judge and appropriate dependency judges to enhance information on court orders for psychological evaluation of foster children, providing greater and better direction to the psychologist.
3. What's needed are clearly articulated expectations for any psychological evaluation as well as clear criteria for reviewing the performance of any contracted psychologist or other expert called on to evaluate children on behalf of the court.
4. Children's Legal Services should work with the chief judge and appropriate dependency judges to explore the need for and use of a "wheel" system to select and assign psychologists for evaluations.

Abuse Hotline

1. DCF should modify the Abuse Hotline procedures to give a greater weight and immediacy to calls from a school district employee.
2. DCF should review the definition and use of "special conditions" referrals.
3. DCF should modify the Abuse Hotline procedures to give greater weight to calls from community-based care agencies and their contracted providers.
4. DCF should take steps through both training and quality control to ensure that intakes from the Abuse Hotline are correctly identified as an immediate response or within-24-hours response.
5. DCF should work with law enforcement to ensure an appropriate joint response when children are not located quickly.
6. Through training, enhanced technology, process improvement and quality control, every effort must be made to insist that all new information is linked to existing cases in a simple and readily accessible fashion.
7. DCF should ensure that "mandatory reporters" in each community are exposed to web-based training available through the DCF to sharpen their awareness and reporting skills for abuse and neglect calls.

Information Sharing and Services Integration

1. DCF should work with the school system and Department of Education to devise an efficient alert system, with appropriate follow-up inspections, for at risk children removed from the school system and placed in "home schooling."
2. DCF, working in partnership with its community-based care lead agencies, should emphasize and mandate the role of the case manager as the "systems integrator" on cases to which he/she is assigned, articulating the leadership role of this position in assembling and supporting the right team to deal effectively with the needs of the child. This includes ensuring the safety, permanency and well-being of each child, providing educational support, full medical and dental services, all needed mental health and therapy services, and necessary child development care and services.
3. Our Kids should work with the Miami-Dade School District to ensure that school personnel are integrated into any team meetings that focus on the needs of a child in foster care.

4. DCF should immediately update its Memorandum of Understanding with law enforcement to ensure an appropriate joint response when children are not located in a timely manner and to ensure that law enforcement is notified immediately when the statutory requirement for immediate notification of abuse and neglect reports is met.
5. Children's Legal Services should work with Our Kids and the assigned judge to ensure that the citizens' review panel recommendations are fully heard and heeded.
6. DCF should meet with the Chief Justice of the Florida Supreme Court to review the assignment and rotation of dependency judges so that each serves for at least 2-3 years on that bench.

Training

1. DCF, working in partnership with its community-based care partners and child welfare experts, should revise the current approach to professional development of investigators, case managers and licensure staff, including pre-service and in-service training and the use of technology. This should include both much deeper specialty training for CPIs in the science and practice of child protective investigation as well as training of CPI and case management supervisors.

2. DCF should review and strengthen the training provided to child protective investigator supervisors.

Technology

1. Our Kids should work with the Miami-Dade School District to develop an interface between the district's system, integrating school-related indicators with those used within the child welfare system.
2. DCF should develop the capability to technologically link existing adoptees within the Abuse Hotline information system when notifying the community-based care agency that services are needed after an abuse or neglect report.
3. DCF should make sure it has the technology to ensure Guardian ad Litem and courts are automatically notified of abuse reports on children in foster care and to encourage them to use Florida Safe Families Network.
4. DCF and Our Kids should work with the Miami-Dade School District to make sure that the case manager has direct technological access to student records for children in foster care.
5. Our Kids should add abuse reports regardless of findings to the existing Child Facesheet within its information system.
6. Our Kids immediately should begin full use of the department's automated child welfare case record as required by federal and state law. This includes fully completing the educational, medical, mental health and other key components of the automated child welfare case record.
7. When an abuse report is received on a child in foster care, DCF immediately should convene a team of all key agencies and involved professionals.

Long-term Recommendations

Personnel Management

1. DCF should examine the recruitment, selection and retention of CPIs, including classification, pay scale, need for competitive area differential, and career development and develop recommendations by May 1.
2. DCF should examine the salary scales within the community-based care agencies and their contracted providers. There is surely a major disparity in compensation and questions of equity when one sees how much less DCF professionals make vis-à-vis those in the community-based care system.
3. DCF should ensure that performance reviews of child protective investigators, caseworkers and supervisors are completed annually and that most importantly individuals on performance improvement plans are held accountable and dealt with in a consistent, timely manner.

Training

1. DCF, working with its community-based care lead agencies, should ensure on-going training of child welfare personnel in trauma-informed care, including how to make trauma-sensitive transitions when it might be best to remove children from their birth family homes, or foster or adoptive homes.
2. Our Kids should work with the Miami-Dade School District to provide joint training of child welfare workers and foster/adoptive parents.
3. Children's Legal Services should take the lead in coordinating training in substantive and litigation skills, including cross-training with Guardian ad Litem and the Office of Regional Counsel.

Service Delivery

1. Our Kids, working with the Miami-Dade School District, should ensure that educational plans are developed for all children in care.
2. DCF should take the necessary legislative and/or administrative steps to ensure that foster children who have been adopted and are being home schooled are seen on a regular basis by case management personnel.
3. DCF, working with its community-based care lead agencies, should ensure that adequate post-adoption services are available throughout the state, and consideration should be given to requiring such services for the first two years when families adopt children with special needs.

Technology

1. DCF, working with its community-based care partners, should develop an electronic medical passport for each child in foster care and link this to the FSFN data base.

Other Thoughts

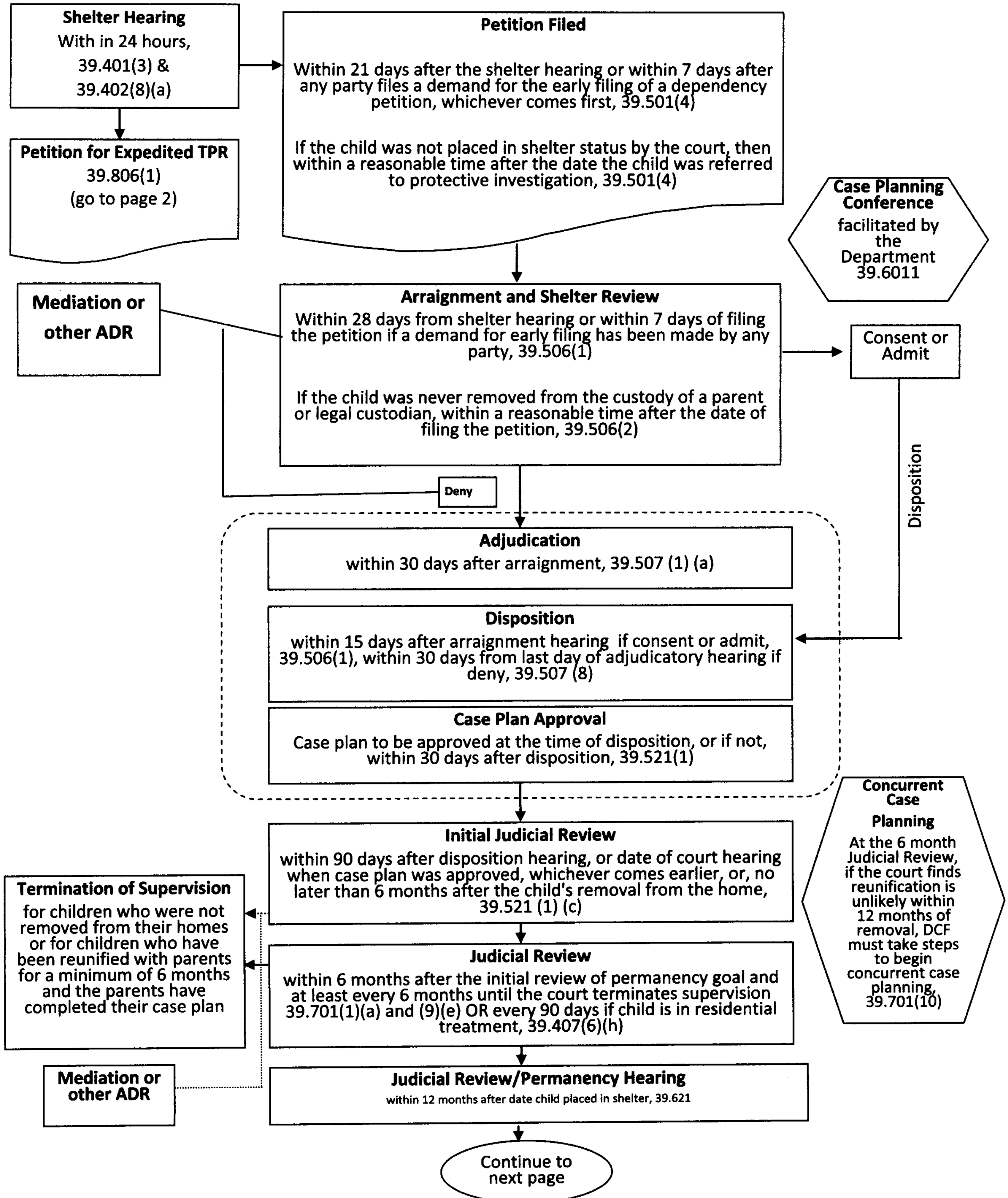
1. The incoming Secretary should undertake a review of the quality of the services performed by Our Kids and its subcontractors. Our Kids of Miami-Dade/Monroe receives about $100 million per year from DCF to perform contracted services. This investigation has raised concerns about the quality of some services delivered by Our Kids and its subcontractors.
2. Children's Legal Services and the chief judge should review practices in the appointment of private lawyers to represent dependent children to ensure that the Rules of Professional Responsibility are fulfilled.

List of Documents Reviewed

The following documents were reviewed by the panel. The complete set of documents is available on the DCF website:

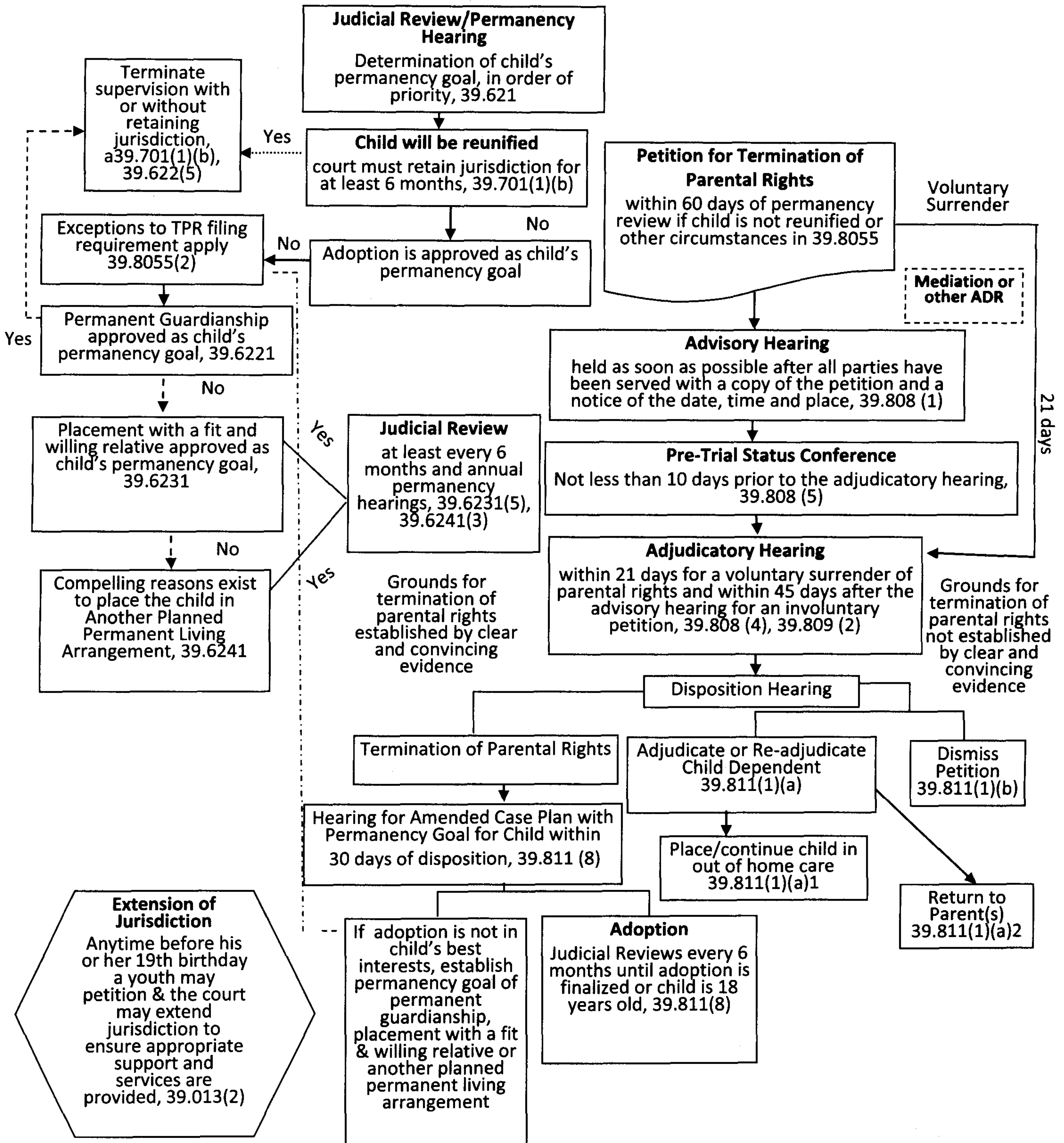
1. Detailed Timeline of Barahona Case Events
2. Transcript from Evidentiary Court Hearing on November 28, 2007
3. Transcript from Evidentiary Court Hearing on February 22, 2008
4. Department of Administrative Hearing - Recommended Order for Case 20061129, C.S. v. DCF
5. Home Schooling Facts, Laws and Questions
6. Written Statement to the Investigative Review Panel by Delores Dunn, CEO of the Center for Family and Child Enrichment
7. Transcript of Oral Statement to the Investigative Review Panel by Delores Dunn, CEO of the Center for Family and Child Enrichment
8. Recommendations for Children's Legal Services to the Investigative Review Panel by Mary Cagle, Director of Children's Legal Services
9. IRS 990 Form for Our Kids, Inc.
10. IRS 990 Form for the Center for Family and Child Enrichment
11. Our Kids, Inc. Budget
12. Psychological Reports
13. Judicial Review Reports and Court Orders
14. Protective Investigation and Case Management Records

DEPENDENCY CASE MANAGEMENT FLOWCHART



DEPENDENCY CASE MANAGEMENT FLOWCHART

(Continued)

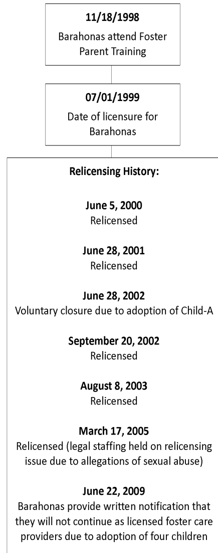


Barahona Case - Key Events

CRITICAL EVENTS / DECISIONS FLOW

Nubia
Born 5/26/2000
Found deceased 2/14/2011

Victor
Born 5/26/2000



11/18/1998
Barahonas attend Foster Parent Training

07/01/1999
Date of licensure for Barahonas

Relicensing History:

June 5, 2000
Relicensed

June 28, 2001
Relicensed

June 28, 2002
Voluntary closure due to adoption of Child-A

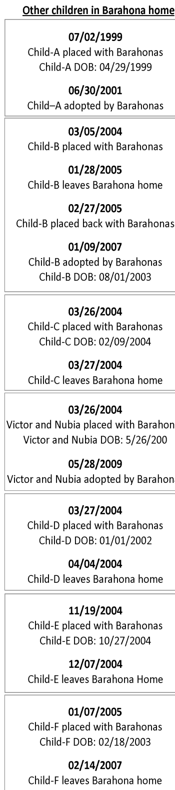
September 20, 2002
Relicensed

August 8, 2003
Relicensed

March 17, 2005
Relicensed (legal staffing held on relicensing issue due to allegations of sexual abuse)

June 22, 2009
Barahonas provide written notification that they will not continue as licensed foster care providers due to adoption of four children

Other children in Barahona home



07/02/1999
Child-A placed with Barahonas
Child-A DOB: 04/29/1999

06/30/2001
Child–A adopted by Barahonas

03/05/2004
Child-B placed with Barahonas

01/28/2005
Child-B leaves Barahona home

02/27/2005
Child-B placed back with Barahonas

01/09/2007
Child-B adopted by Barahonas
Child-B DOB: 08/01/2003

03/26/2004
Child-C placed with Barahonas
Child-C DOB: 02/09/2004

03/27/2004
Child-C leaves Barahona home

03/26/2004
Victor and Nubia placed with Barahonas
Victor and Nubia DOB: 5/26/200

05/28/2009
Victor and Nubia adopted by Barahonas

03/27/2004
Child-D placed with Barahonas
Child-D DOB: 01/01/2002

04/04/2004
Child-D leaves Barahona home

11/19/2004
Child-E placed with Barahonas
Child-E DOB: 10/27/2004

12/07/2004
Child-E leaves Barahona Home

01/07/2005
Child-F placed with Barahonas
Child-F DOB: 02/18/2003

02/14/2007
Child-F leaves Barahona home

05/30/2000
HOTLINE
"Special Conditions"
- Parent needs assistance: substance exposed newborns

06/16/2000
Shelter hearing; both children were court ordered in shelter status while still hospitalized

07/26/2000
Victor released to custody of biological mother. Nubia remains in foster care.

08/23/2000 10/23/2000 and 11/15/2000
Judicial Reviews

01/08/2001
Nubia returned to custody of biological mother

07/09/2001
In-home supervision terminated by court

03/17/2002
HOTLINE
- Allegation of domestic violence; biological mother arrested

03/18/2002
Verified findings of violence, substance exposed children; Safety assessment completed and no other actions taken or services offered

Investigation subsequently reviewed as part of Backlog Reduction Project

A Child Protective Investigator visits the home on March 9, 2003, consults with Nubia's doctor. The findings prompt court action.

03/10/2003
Shelter hearing and children placed in custody of biological father.

Termination of Parental Rights filed on biological mother

08/04/2003
Biological mother's parental rights are terminated

Judicial Review held; children remain in custody of biological father

Termination of Parental Rights order allows biological mother to visit with the children as long as visits are supervised by biological father

No further services ordered by the court

01/02/2004
HOTLINE
- Biological mother back in home; allegation of emotional abuse

02/06/2004
Investigation closed with no indicators of abuse

03/26/2004
HOTLINE
- Allegation of sexual abuse of a non-related child by biological father

03/26/2004
Twins sheltered in the Barahona foster home. Department contacts the twins' paternal aunt and uncle in Texas for placement four days later

04/14/2004
Order changing the custody from biological father to DCF

Motion filed for Interstate Compact on the Placement of Children study (Texas).

06/30/2004
Order accepting case plan. Goal: reunification with biological father. No contact with children allowed.

12/24/2004
Judicial Review: weekly therapeutic visits with Victor and Nubia ordered

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01/27/2005
HOTLINE
- Foster father has allegedly sexually abused Nubia

02/25/2005
Investigation closed with no indicators

02/24/2005
Judicial Review Order; Biological father complying with treatment

04/19/2005
No contact order issued in criminal court Biological father arrested for sexual abuse of Victor and Nubia

06/29/2005
Positive home study on paternal aunt and uncle

08/04/2005
Evaluation court ordered to determine permanent placement. Guardian ad Litem report recommends Barahonas over relatives.

09/07/2005
Psychological evaluation; placing children with aunt and uncle would be traumatic

09/14/2005
Petition for Termination of Parental Rights on biological father filed.

11/28/2005
Motion by biological father to change custody to Texas relatives

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02/23/2006
HOTLINE
- Allegations that Nubia has bruises on chin, face; has been absent from school

03/06/2006
Child Protection Team examines Nubia and determines bruises not from abuse

04/10/2006
Investigation closed with no indicators of abuse

06/29/2006
Judicial Review; goal of adoption; visitation with biological father prohibited Guardian ad Litem and the agency recommend children remain with Barahonas

11/02/2006
Judicial Review; goal of adoption

Guardian ad Litem and the agency recommends children remain with Barahonas

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02/16/2007
Amended petition for Termination of Parental Rights for biological father filed

03/20/2007
HOTLINE
- Victor and Nubia are allegedly coming to school unkempt

04/12/2007
Investigation closed with no indicators

05/29/2007
Termination of Parental Rights ordered on biological father

Guardian ad Litem and the agency recommend continued care with Barahonas

06/06/2007
Pediatrician submits letter to Children's Legal Services describing medical care of Nubia and endorses mother's care of child

08/03/2007
Evidentiary hearing on suitability of Barahona home placement. Court receives written request from Texas relatives to be the permanent home.

10/19/2007
Order for Educational Review (poor grades, grade retention)

02/12/2008
Dr. Archer completes evaluation on Victor and Nubia and recommends adoption by the Barahonas

05/12/2008
Judicial Review
Guardian ad Litem and the agency recommend children remain with Barahonas

10/16/2008
Biological father loses his appeal for Termination of Parental Rights

Victor and Nubia are now briefed for adoption

01/14/2009
Judicial Review before Citizen's Review Panel

Guardian ad Litem and the agency recommend the Barahonas as the adoptive parents for Victor and Nubia

05/28/2009
Victor's and Nubia's adoptions finalized with Barahonas

05/28/2009
Victor's and Nubia's adoptions finalized with Barahonas

06/22/2009
Letter from Barahonas stating foster care license will not be renewed (reason of having a complete family)

06/09/2010
HOTLINE
"Special Conditions"
-Allegation that Nubia's hunger is uncontrollable, hair loss, jittery

06/24/2010
Case closed

No indication of family needing services

2011 and thereafter
Calls to the HOTLINE

Information not posted due to criminal investigation