

The Nubia Report

The Investigative Panel's Findings and Recommendations

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Presented to:
David E. Wilkins, Secretary
Department of Children and Families

March 10, 2011

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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 but only if correctly and consistently applied 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. But technology should never substitute for the exercise of critical thinking, sound judgment and common sense. 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. We emphasize: There is no substitute for critical thinking and common sense.

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 be 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