NUBIA'S LEGACY: CONFRONTING THE BIAS OF TRUST AND COMPLACENCY IN FLORIDA'S CHILD WELFARE SYSTEM

I. INTRODUCTION

Our term as grand jurors was interrupted with the horrific news stories of the tortured existence of Nubia and Victor Barahona. We had been carrying on with our lives, and fulfilling our job as jurors while at the same time utterly unaware of what was happening in another part of our county. We had no idea that two children were imprisoned in a bathtub, bound with duct tape, fed milk and bread once a day and left to sleep, night after night, on the cold porcelain surface.

We heard the evidence and indicted Carmen and Jorge Barahona for the death of Nubia and the abusive treatment over time of both Victor and Nubia. The testimony we heard will stay with us forever, as a bad dream will sometimes stay, only this was not a dream but a reality too painful to fathom. The how and why of this is no longer ours to consider. It is now a criminal case set for trial. We leave that to others with the fervent hope that justice will be done.

One has only to spend the slightest of moments and imagine this tortured existence to know that something must be done to make sure this can never, ever happen again.

After hearing the evidence presented in support of the Indictment against the Barahonas, we decided that our investigation would, in part, take a look at our Child Welfare System to see if we could make recommendations that could stop another tragedy from happening again.[1] To be clear, we will not be presenting an examination of everything that went wrong on the Barahona case. That has already been done.[2] Instead, what we do in this report is make recommendations for changes that we believe will improve our Child Welfare System.

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[1] Although some may view the case with Victor and Nubia as an aberration or an isolated incident, we are aware that over the years there have been other children in foster care that died or were otherwise abused. This report is designed to expose weaknesses in Florida's foster care system to keep the next tragedy from occurring.

[2] Shortly after the death of Nubia, David E. Wilkins, Secretary, Department of Children & Families established an Independent Investigative Panel comprised of David Lawrence, Jr., Roberto Martinez, Esq. and James D. Sewell, Ph. D. The assignment given to the panel was to review what happened and come up with recommendations that could be achieved within ninety (90) days. Additionally, the panel was to identify other issues and practices that the department and its contract providers must review in depth over the coming months. The result of the Panel's work was a document released on March 10, 2011 entitled, The Nubia Report. That report is available online at http://www.dcf.state.fl.us/initiatives/barahona/barahona.asp?path=Barahona%20Independent%20Review%20panel/

For those not familiar with the Barahona case, it is necessary that we first present a brief account of the facts.

The twins, Victor and Nubia, came into Florida's Child Welfare System in 2000. Eventually they were placed in the care of foster parents Carmen and Jorge Barahona. The Barahonas had previously served as foster parents to other children within the system. After five years of serving as foster parents to the twins, the Barahona's were approved to adopt them. The adoption was finalized in May 2009.

From the time of their initial placement in the foster home of the Barahonas and until the time of the arrest of the Barahonas, the Department of Children & Families ("DCF" or the Department) had received five calls to the Florida's Child Abuse Hotline regarding Victor and/or Nubia. The information given to Hotline Counselors included allegations and information as follows:

- A January 2005 call alleging that Nubia had been sexually abused by her foster father, Jorge Barahona;[3]
- A call in February 2006 alleging physical abuse of Nubia after she missed several days of school and was observed with bruising around her neck and chin area;
- A February 2007 call alleging that Victor and Nubia were coming to school unkempt, they were falling asleep in class and at times were afraid to go home. It was further reported that Nubia was always hungry and eating a lot of food at school;
- Following the adoption of Victor and Nubia in May 2009, the Hotline received a call in May 2010 alleging that Nubia was suffering from hair loss, weight loss and she was unfocused and jittery at school. Similar to the Hotline Call in February 2007, it was reported again that Nubia was always hungry and eating a lot of food at school. In fact, her hunger was described as "uncontrollable"; and
- A February 10, 2011 call alleging that Victor and Nubia were being tied up by their hands and feet and made to sit in a bathtub for extended periods of time.

On February 14, 2011, four (4) days after the February 10th call to the Hotline, a Road Ranger noticed a red pick-up truck on the side of I-95 in West Palm Beach. The Road Ranger was able to see a man near the truck, on the ground, eventually found to be Jorge Barahona. He also saw on the passenger side front cab of the truck a male child, later determined to be Jorge

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Final%20Report/List%20of%20Documents%20Referenced. Similarly, while the Investigative Panel was conducting its investigation, Secretary Wilkins had members of his staff begin DCF's own investigation. The results of that investigation were released on March 14, 2011 and can also be found at the same website.

[3] The investigation of Jorge Barahona in connection with this incident was ruled unsubstantiated as investigators determined that the alleged abuser was not Jorge Barahona.

Barahona's ten-year old adopted son, Victor, who appeared to have serious medical problems including skin burns and trouble breathing. While police were investigating, the body of a young female was discovered in a bag, deceased, decomposed, and soaked with hazardous liquid in the rear flat bed of the vehicle. The body was that of Jorge Barahona's ten-year old adopted daughter, Nubia.

This Grand Jury returned a True Bill on March 23, 2011, indicting Carmen and Jorge Barahona, charging them with, among other things, First Degree Murder and multiple counts of Aggravated Child Abuse and Child Neglect. Victor and Nubia had been removed from the homes of their biological parents because the state was concerned that, had they remained in that environment, they would be in danger. Therefore, after removing them, the state placed Victor and Nubia with the Barahonas, adults who had been screened by the state and sanctioned to provide a loving and caring home for the twins. These "loving and caring" individuals allegedly abused the twins, killed Nubia and tried to kill Victor. The state figuratively pulled the children out of the frying pan and threw them into the fire. That is **not** how this system is supposed to work.

We discovered two factors that combined to exponentially raise the risk of disaster: a dangerous bias of trust and a failure to view or recognize or take into account the full picture. Simply put, a bias of trust is an untempered acceptance of what one person says without a healthy dose of skepticism. Failure to view the full picture is a failure to combine and correlate information in a manner that makes the whole greater than the sum of its parts, that clarifies the facts, and that therefore properly focuses the system.

In the world of child protection, this combination is a recipe for disaster. As to Nubia and Victor, it allowed murder, torture and child abuse.[4] Much of the bias of trust related to the work of two major participants in the system: Child Protective Investigators (DCF employees who investigate referrals from the Hotline) and Case Managers (Our Kids' subcontractor employees who are tasked with handling individual cases of children who have been placed in the dependency system.)

[4] Our findings are not in any way intended to excuse the acts of the Barahonas.

The sad reality is if the Barahonas had been the biological parents of Victor and Nubia, a more thorough investigation probably would have been conducted following the various reports called into the Hotline. If the Barahonas had **not** been foster parents, instead of getting a "pass", Child Protective Investigators and Case Managers might have engaged in more critical thinking as it related to the "big picture" of what was happening with the kids. DCF's mission is supposed to ensure that dependent children are placed in a nurturing environment where they are given the basic necessities of life; **food**, **shelter**, **clothing**, **medical care** and **security** in a loving home. However, this "bias of trust" and failure to see the whole picture resulted in the exact opposite happening.

Instead of being fed, Nubia was starving for food (officials should have known she was in trouble because her hunger at the school was uncontrollable). Her shelter was not a refuge, but a torture chamber (officials should have known she was in trouble because they saw some of the bruises she sustained from the physical abuse). She was clothed but she was not cared for in that regard (they should have known because she went to school unkempt with food in her hair for days in a row). Medical services, medical care and dental care were available for Nubia and Victor free of charge to the Barahonas, but they were not taken to appointments for basic medical services (officials should have known they were both in trouble because Nubia's hair was falling out and she was losing weight, a search of their records would have revealed multiple missed medical appointments, and notes from a nurse practitioner clearly stating that the Barahonas were very poor caretakers for not attending to the required medical care **needed** by the children). Finally, instead of finding security at the Barahona home, Nubia found herself living a nightmarish existence (officials should have known she was in trouble because they saw that she was jittery in school and knew she was afraid to go home). Yes, this bias of trust and failure to see the whole picture helped to kill Nubia and injure Victor. The Barahonas, who had been longtime foster parents were "so wonderful" because they adopted these children (and others). Based on that history of being "saviors," no one wanted to recognize them for what they apparently were, monsters.

II. FLORIDA'S CHILD ABUSE HOTLINE

Many of the children who come into contact with Florida's Child Welfare System do so based on third-party reports of abuse or neglect being inflicted on those children. These reports

are usually made via calls to the System's central reporting center, Florida's Child Abuse Hotline (the "Hotline"). All of the calls are to a 1-800 number and are answered by DCF Hotline Counselors in Tallahassee. Reports can also be submitted online or by fax. Reports called in to the Hotline may occur as a result of observations of the children by neighbors, teachers, relatives or anyone else coming into contact with the children.

Many children in Florida's Child Welfare System end-up there following investigations conducted by DCF Child Protective Investigators (CPIs). Those investigations are initiated primarily based on the calls and reports made to Florida's Child Abuse Hotline. If the reported information meets statutory criteria, a report is forwarded to a Child Protective Investigator who works in the DCF Regional Office where the child resides.

In calendar year 2010, the Hotline had 295,064 "Child Calls Answered."[5] Thus, Hotline Counselors play a significant role in Florida's Child Welfare System. In addition to receiving the calls and logging essential information from callers, the Hotline Counselors also assess the information they receive and make a determination as to the type of response (if any) that should be initiated by DCF.

The Department of Children and Families' goal is to act with a sense of urgency to all allegations of harm to children and/or vulnerable adults. The Florida Abuse Hotline's goal is to submit all reports to the appropriate investigative office within one hour after the call to the Hotline ends. Once the report arrives at the investigative office and is assigned to an investigator, the investigator has up to 24 hours to initiate contact with the subjects of the report. In situations in which it is believed the victim is at imminent risk of harm, the investigator will respond as soon as possible. Obviously, since Hotline Counselors "classify" the calls, they should be sufficiently trained to make appropriate assessments of the information they receive.[6] This was one of the shortcomings we saw in this regard related to the Barahona case.

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[5] http://www.dcf.state.fl.us/programs/abuse/

[6] The minimum education requirement for all Hotline counselors is a Bachelor's degree from an accredited university. In addition, all Hotline counselors are required to complete a nine week pre-service training prior to taking calls in the Hotline's call center. This training includes seven weeks of classroom training and practice, and concludes with a two week service practicum. During the practicum period, trainees are taking live abuse hotline calls, but have a trainer, supervisor, or veteran counselor with them to assist and review their decisions and reports. On-going, in-service training is conducted annually with all Hotline Counselors. http://www.dcf.state.fl.us/programs/abuse/faq.shtml

One of the last calls made to the Hotline regarding the twins occurred on February 10, 2011 and alleged that Victor and Nubia were being tied up by their hands and feet and made to sit in a bathtub for extended periods of time. Clearly, the nature of this information should have resulted in an "immediate response" classification. It did not. Further, inasmuch as the conduct reported was also a crime, there should have been an immediate referral to law enforcement. There was not. Therefore we make the following recommendations:

We recommend that all Hotline Counselors (and their supervisors) receive training to improve their ability to classify cases where they deem sufficient criteria have been met for filing a report.

We recommend that all Hotline Counselors (and their supervisors) receive training sufficient for them to be able to identify allegations that amount to criminal activity.

We recommend that strict compliance be required of all Hotline Counselors (and their supervisors) in regard to the immediate reporting to local law enforcement of all cases where the conduct reported to a Hotline Counselor amounts to criminal activity.

We recommend that DCF Regional and local investigative offices be given the authority to reassess, reevaluate and reclassify all DCF response times included in any report received from a Hotline Counselor.

Another area of concern involved the Hotline and technology or more appropriately, the lack thereof. Here we begin to see the failure to obtain the whole picture. The shortcomings we noted with the Hotline system is the inability of the counselor to upload pertinent data while the caller is providing information. If the caller gives a name, address or other identifying information for a specific child, the counselor would be able to make a better assessment if he had at his fingertips information of prior Hotline calls or investigations involving the same child, the same address, the same family or the same parents, guardians or caregivers. The available data should also reveal the timing of when the other calls, reports or investigations took place. The availability of this additional information could prove priceless, as the counselor is able to get the whole picture of what has been happening, as opposed to a present evaluation of what may appear to be a singular incident. This additional historical data could also accompany the report sent by the counselor to the CPI and Case Manager.[7] The technology to be able to achieve these two goals is not available at DCF presently. However, in discussing this with Secretary

[7] *See infra* at 13 for the Case Manager job description.

Wilkins, we discovered this was one of his priorities too. He has already positioned himself to ask the legislature for additional funding to bring these technological advances to this area.

We recommend that the Florida Legislature, even in light of our limited tax dollars, adjust other budgets to find sufficient resources for these critical technological improvements to the Child Abuse Hotline Center.

III. CHILD PROTECTIVE INVESTIGATORS

Child Protective Investigators are DCF employees charged with the responsibility of investigating allegations of abuse or neglect that usually come in through the Hotline. The enormity of their work cannot be overstated. They literally make life and death decisions throughout the course of their career. This is where we began to see the bias of trust and to recognize how it infects our entire system. We cannot afford anything other than a healthy dose of skepticism as applied to the work of the CPIs. Furthermore, considering the potential consequences, the job qualifications are remarkably undemanding, given the investigative nature of the work. In addition, the starting salary of $34,689 per year is woefully inadequate in terms of attracting superior candidates for this very challenging position.

The essence of much of the work done by CPIs is the same as that of law enforcement. A CPI comes into a case, more often than not, having had no contact with the child or family. **They are supposed to come into the situation with no bias to believe or disbelieve any one person.** They are there to investigate and to find the truth. They respond to a home, are expected to interview victims, witnesses and subjects, and in many instances come to a conclusion that is frequently the same or similar to deciding whether a crime has taken place. In fact, many of the allegations investigated **are** crimes and many acts of child abuse may be criminal in nature. It therefore boggles the mind that CPIs have no adequate law enforcement training and are not required to have law enforcement experience. They are underpaid civilian employees doing the work of the police without the requisite background to do so. That shortcoming may help to explain why the quality of the work done by CPIs in the Barahona case was so abysmal.

The response to the February 10, 2011 hotline call is a perfect and horrifying example of the bias of trust and need for improvement in the CPI arena. As mentioned above, there was a call to the Hotline alleging that Victor and Nubia were being tied up and forced to sit in a bathtub. The Hotline Counselor qualified the call as "needing a response within 24 hours." How this designation was assigned is beyond us. Not only did this call require an **immediate**

response, it should have required a call to 911 with the designation that it amounted to a kidnapping or false imprisonment, two extremely serious felony charges.

The CPI responded to the home four hours after she had received the report. Prior to going to the home to investigate these allegations, the CPI gave no consideration to perhaps accelerating the pace of the investigation given the nature of the allegations. Where was the basic common sense and initiative necessary to do this type of work? Even if the Hotline Counselor had labeled this "not so serious," how is it acceptable that the "qualification" was not questioned and changed? Prior to going to the home, the CPI did no "homework" on the case. There was no research done into the background of this particular family to determine if there were any prior allegations of abuse. How is an investigator supposed to know what they are walking into if they don't have any information about the family? The fact that she did not conduct any research further demonstrates her bias of trust and demonstrates the critical necessity of having a law enforcement perspective. No police officer in the world would go to investigate a crime as serious as this without running the subjects' priors. This CPI was lacking the preliminary information necessary to decide how aggressively to pursue these allegations

When the CPI arrived at the Barahona home the gate was locked and she did not see any vehicles. What was her response? She left. Were Nubia and Victor in the house tied up in that bathtub at that very moment? We will never know. However, no one with real law enforcement training, investigating allegations such as these, would have just left that house without knowing whether those children were inside and, if so, what condition they were in. No one with real law enforcement training, investigating allegations such as these, would have so easily given up at that point on finding the children.

The CPI took no further action on the Barahona allegations that day. She did not call her supervisor to report that she had not been able to locate the children nor did she call whoever was working the next shift to get them to take over immediately. She did nothing.

On the next day, the CPI contacted school officials and learned that the children had been taken out of public school and were now homeschooled. She did nothing else on the Barahona case until approximately 9:30 that night. She returned to the home and again attempted to get past the locked gate. She could not. She called a coworker for the phone number to the home. Why did she not have this basic information? Something as simple as contact information for

these adoptive parents should have been ready to use, in her hand. This also raises the question, why didn't she try to make a call when she was there the day before? Simply because she didn't see a car? Or, was it really because she had 24 hours within which to complete her assigned task and now her "allowed" time was running out? Either way, this was clearly not the level of investigatory aggression called for with these allegations.

Eventually, the CPI did make contact with Carmen Barahona at the home. The CPI was told by Carmen that Jorge Barahona had the children and that Carmen had not seen the children for three weeks. The CPI's response? She simply told Carmen that if (why "if"?) she had any contact with Jorge (**her husband**), to tell Jorge that the CPI needed to see the children. The CPI left. She still had not seen the children. The CPI accepted the excuses Carmen gave for the children not being present. She never searched the house and never looked in the bathroom or the bathtub. Instead of investigating for herself, she simply accepted what the person accused of abusing the children told her. She trusted their answers and looked no further.

Why did she do that? What caused it? Complacency? Laziness? An internal, inherent lack of skepticism? We mentioned earlier in this report that all CPIs must enter a case with a healthy dose of suspicion, not a bias of trust. They should not demonstrate a grain of trust. To preclude this, to truly investigate, to find the truth, what she should have done was to push harder, call law enforcement, ask for names of others who could verify the story. She should have gotten a telephone number (or other address) for Jorge Barahona. She should have questioned the other children (of course, to be effective at all, this must be done outside the presence of the person accused, in this case Carmen Barahona. To question the children in the presence of any subject is folly indeed.) She should have looked in the house to see if there was evidence that the children were still living there. She should have looked in the bathtub. She did none of these. It apparently was sufficient investigation in her mind to go to the home, speak to the subject of the complaint, simply accept her story and walk away, job done.

On February 12, 2011, the CPI did "input notes" and prepared a child safety risk assessment, which is a tool to assess risk for children who are the alleged victims of child abuse. The CPI concluded that the risk was low as to the children in the home. Our opinion is that a risk assessment could not have been made because the CPI had not yet made contact with the children who were the subject of the abuse report. The CPI did nothing further to find Nubia and

Victor. Two days later, the CPI learned that the children had been found; Nubia was dead and Victor was severely injured.

The entire protocol and perspective for investigations such as these must change radically. The lack of common sense and critical thinking here is astounding. The lack of basic investigative instincts is appalling. This must change through training. Every CPI should embark on a case with a healthy dose of suspicion. This will assist them in their investigation and make them more dogged in their pursuit of the truth and more careful in coming to a conclusion.

There are a number of recommendations that stem from an analysis of what the CPI did and did not do in the Barahona case. They are:

We strongly believe that the essence of the job of a CPI is one of law enforcement more than social work. We therefore recommend that the qualifications for the position of CPI be altered accordingly and require more education and/or experience in that realm.

We recommend more training of a law enforcement nature for CPIs.

We recommend that a requirement of case background review prior to initiating a home visit pursuant to a Hotline call be instituted and in instances of extreme emergency, that a protocol be developed for providing the case background information to the CPI en route by telephone.

We recommend that each CPI have 24 hour access through a portable device to the entire case file.

We recommend that CPIs or their supervisors have the authority and responsibility to escalate a classification of a reported case of abuse received from the Hotline Call Center.

We recommend for CPIs that, in order to preclude this bias of trust, a requirement to conduct investigative steps like those listed above, must be made mandatory with appropriate punitive action for lack of compliance.

We recognize that DCF has entered into a Memorandum of Agreement with the various police departments to have a police officer accompany CPIs on investigations. We would like to say at the outset that we do not feel that this is a substitute for each CPI, as an individual, gaining for themselves a greater law enforcement perspective when investigating allegations of abuse and neglect. As it is too early for us to do so, we ask that a future Grand Jury look at this issue at a point where it has sufficiently evolved for proper evaluation.

IV. PRIVATIZATION OF FLORIDA'S CHILD WELFARE SYSTEM

In 2005, child welfare services became privatized in this county. A new era had begun. Prior to that, services were the responsibility of DCF. Under the old system, once a

determination was made that a child would be removed from a home, DCF would then determine what type of services should be provided for that family or child. If the child was removed from the parent/guardian, DCF would then be charged with placing the child in an appropriate setting to ensure that the child's needs would be met and that the child would be afforded the appropriate care for her physical, mental, emotional, psychological and educational needs. DCF would also see to it that all appropriate services or counseling would be provided to that child, including foster care.

Florida now has twenty (20) Community Based Care (CBC) Lead Agencies that have contracted with DCF to tackle this huge responsibility of shepherding and processing children who end up in foster care. The CBC Lead Agencies are also involved in making sure services (more preventive in nature) are being provided to those children who are in need of services, but still living at home. Some of these CBC Lead Agencies conduct the provision of services function that used to be performed by DCF.[8] However, many of the Lead Agencies contract with other providers (Full Case Management Agencies) that have the ability to provide such services. Our Kids is the CBC Lead Agency for Miami-Dade County, and it follows the latter model. In order to appreciate some of the recommendations contained herein, it is necessary to describe how this privatization system operates here.

Our Kids entered into a multi-year services contract with DCF to assume responsibility for intake and placement services, foster home management and child welfare case management and the administration and management of child welfare services in Miami-Dade and Monroe Counties. Our Kids contracts with Full Case Management Agencies which actually provide the intervention, prevention, shelter and group care, assessment and case management services.

Our Kids also serves as a pass through entity for federal and state dollars that are distributed to the Full Case Management Agencies who are directly providing services to the children in foster care and their families. Our Kids receives approximately $100 million dollars annually that it uses for various purposes.

[8] For instance, in Broward County, Child Net is the CBC Lead Agency and it actually provides services as a Full Case Management Agency.

Our Kids has entered into contracts with six (6) Full Case Management Agencies (five in Miami-Dade County[9] and one in Monroe County[10]) that actually provide services to the children and parents/guardians who become involved in our Child Welfare System. When an allegation of abuse or neglect has been substantiated by a CPI and a child has been removed from a home in this county, that child (and that new case) becomes the responsibility of Our Kids, the CBC Lead Agency. Based on the child's geographical location in the county, the child is placed in the care of one of five (5) Full Case Management Agencies (FCMAs) providing services to the foster children and their parent, foster parents or guardians. A Case Manager is then assigned to that file (and to that child) and assessments are begun on the needs of those children. Based on a number of factors including age, gender, psychological or physical disabilities, the number of siblings, etc., the children are "placed" in an environment that should be nurturing and productive. In addition to possible placement with other family members, other options for placement include having the child placed in foster homes, temporary shelters or group homes. Wherever the child is placed, the services are provided by the Full Case Management Agencies. We wondered whether having DCF contract with the Lead Agencies and then having those Lead Agencies contract with the Full Case Management Agencies was an effective and efficient model. We decided we would look next door to get a different version of how these services can be provided.

The Broward County lead agency is "Child Net." Broward County has a population of 1,748,066[11], much smaller than Miami-Dade at 2,496,435[12] and consequently Child Net has a smaller budget, $67 Million. When Child Net began in 2003, it was much the same as Our Kids. It was an umbrella/administrative organization that operated as a liaison between the State and a number of private agencies who were contracted to perform the work of caring for those Broward children in need of care. As the years progressed, a change was made. It was decided that some of the work contracted out would be better done "in-house." That is, the work would be better done by Child Net itself. There were three reasons for this change that are relevant to

[9] Those Full Case Management Agencies in Miami-Dade are His House Children's Home, Children's Home Society of South Florida, Inc., CHARLEE (Children Have All Rights: Legal, Educational and Emotional), Family Resource Center and the Center For Child Enrichment.
[10] The Full Case Management Agency in Monroe County is Wesley House Family Services.
[11] U.S. Census Bureau 2010
[12] Ibid.

our considerations. The first was so that Child Net would have a greater hands-on understanding of the complexities of the work done in the field. Second, there was a desire to exercise greater control over consistency in performance. Finally, Child Net's administrative costs of contracting out the work could be saved by keeping the work in-house.

Therefore, we recommend that DCF require all lead agencies to handle some full case management responsibilities in-house.

V. THE CASE MANAGER

The concept of the bias of trust and the failure to grasp the whole picture is even more insidious when considered in the context of the work of the Case Manager, one of the most significant jobs in the foster care system. Case Managers are employed by the FCMAs and they "manage" the cases of the children who have been assigned to their individual caseloads. Most of the Case Managers have caseloads of approximately twenty cases. We received information that this is the average and we trust that if more kids come into the FCMAs that they will hire more Case Managers to keep the caseloads low. A manageable case load is an essential component to doing an effective job.

One of the most critical duties of the Case Manager is to ensure the well being of the children; make sure they are safe; ensure they are being fed and clothed properly, that regular doctor and dental appointments are being scheduled for them, that they are being taken to their doctor's appointment and that they are flourishing (or at least not deteriorating) in their placement.

In this case, prior to the adoption of the twins, Case Managers were assigned to manage the Nubia, Victor and other children in the Barahona home. The Barahonas had been licensed as foster parents and the Case Managers dealt regularly with them. They knew that the Barahonas wanted to adopt children. Anyone would think that the Barahonas were "wonderful people" because not only did they want to adopt children, they wanted to adopt Special Needs children. And, not just one Special Needs child, but two, having already adopted two other children.

All of this adds up to the Case Manager having an absolute bias of trust in dealing with them. Time and time again, when the red flags were waived, as pointed out in the DCF Report,

little or no follow-up or verification was done to determine the truthfulness of the surrounding circumstances of various allegations.

As with the CPI, there must be a mandatory requirement that when a problem is raised or appears, there must be a complete investigation which includes a complete review of the case file, interviews done of all third parties and face-to-face interviews done of all members of the household, again away from the subject of the investigation. Although some of this may sound very basic, it was not done here.

We have seen throughout this investigation, as well as here in the discussion of the Case Worker, that there is a "bias of trust." In any given situation, it seems that there was blind acceptance of statements without verification. This has proved to be a very unwise bias. There is a need to adopt a more prudent and cautious approach. Verify. Corroborate. Make sure the information that is being received is accurate. Enter each case with a presumption of caution.

We recommend for Case Managers that again, in order to preclude this bias of trust, a requirement to conduct investigative steps like those listed above, must be made mandatory with appropriate punitive action for lack of compliance.

All Case Information in One Place, Accessible to All

During the course of our investigation, it became apparent that one factor that exacerbated the bias of trust issue in the Barahona case was that all the participants in the process were not aware of all the information necessary to come to a wise and sound opinion regarding the children. We learned that not all the information about the case was kept in one place and not all participants had access to all information. When a Case Manager does not have the full picture, it is even easier for the bias of trust to creep in and control critical decision-making.

There is a database and system that is used for tracking children in Florida's foster care program. According to information obtained from DCF's website, it is utilized by workers at Florida's Abuse Hotline, Child Protective Investigators, Community Based Care Case Managers, Adult Protective Investigators, DCF Administration, DCF's legal units and persons involved in licensing. All information obtained by the Case Manager should be entered into this system. If everyone who is required to do so makes entries into the system, everyone involved in the case

will have complete up-to-date information and, most importantly, the ability to see the whole picture.

With all the capabilities of the database and system and with all of the categories of persons who are supposed to input data into it, the **effective** use of this existing system would go a long way to providing thorough, up-to-date, comprehensive information on every child in Florida's foster care system. The information would also be accessible to anyone working within the system that had a need for the data. The main reason it is not effective is because all persons who have data to input are not using the system and many who are using it provide incomplete or insufficient information.

Further, we learned that despite the existence of one computer system that could have housed all the information, because of difficulties in using that system, all the FCMAs are not inputting all the necessary information into that system. Counterproductively, some FCMAs even purchased their own systems. The bottom line is there was no single place one could go and get all the information needed on what was happening with Victor and Nubia.

Picture this: a person conducting an investigation sits before a computer screen and runs a child's name or the child's family name or the name of a sibling or the foster parent's name or the parents' names or the court case number or the case management case number or the DCF case number. On the screen appears chronological information starting from the very moment that child came into the Child Welfare System and includes every single thing that has happened on that case, including scanned in medical and psychological appointments and reports, school records, records of hotline calls, dental appointments and results, motions filed in court, court orders, etc. Each is listed as an event with the current status and result. As one reads through this chronology of events, one has the full picture of all that has been going on in that child's life. One also can look at that information and look for patterns and problems, things that, standing alone, may mean nothing, but when seen together, paint a picture that requires further investigation. This is what Nubia and Victor needed. Someone who could view everything about their lives in one place and then see what is now obvious to everyone. That something was terribly, terribly wrong.

As a nation, we have for over a decade recognized that one of the great failures leading to September 11, 2001, was the lack of information (or intelligence) coordination. Our national

security was threatened, many would argue, because of our fractured and disjointed system of information gathering and storing. We have made great strides in first, recognizing that as a basic problem and, second, in doing something about it. Yet, that very same theory has not been applied to child protection. It is time that we do. To correct this problem, the first order of business then would be to have one system where all the information about a case can be maintained.

*We recommend that DCF develop a policy that requires strict compliance by all persons who are required to input data into **one** database system. This will apply to all DCF employees and all agencies involved in the Child Welfare System including all Lead Agencies and FCMAs.*

*We recommend that DCF develop a policy that will impose discipline or punitive measures for those who fail to comply with the strict policy to input all necessary data in the **one** database system. This will apply to all DCF employees and all agencies involved in the Child Welfare System including all Lead Agencies and FCMAs.*

The Case Manager Must Recognize Red Flags and Patterns

It has been suggested to us, and we wholeheartedly agree, that there must be a point person, someone who will take charge of each case. In other words, there must be one designated person who has the responsibility of knowing everything about a case and making absolutely sure that knowledge is communicated to every person who has a need to know the information. The most logical and best way to accomplish this is to assign the Case Manager the job of being the point person. This has been referred to in testimony as "owning the case." Part of owning the case is the responsibility to recognize red flags. This responsibility goes further to include the requirement of recognizing patterns that are readily apparent when one views all the events in one case, in one place.

Our Kids has recognized, in it's Corrective Action Plan, the need for a Case Manager to own the case. We believe this needs to be taken one step further. We looked in detail at a list of the red flags in this case. When we looked at that list, all in one place, we were left with such an undeniably clear picture that we failed to see how anyone could have missed the point that the Barahonas never should have been re-licensed as foster parents, much less received approval for adoption. To make the point, the list follows.

- April 2004: Caregiver (foster parent) needs to be involved in Nubia and Victor's lives and school progress
- December 2004: Nurse informed Case Manager that

- Nubia had missed follow-up medical appointments for a year (needs to see doctor three times a year for Special Needs issue)
- Foster parent never goes with children to doctor, has transportation take them
- The child is not in a good placement because the foster parent does not care for the child's well-being
- Nurse recommended medical foster home
- Nurse expressed concern if child is adopted by this caregiver as she would have sole responsibility to care for the child
- The children have not had their 4-year-old shots
- Doesn't know how the children are in daycare without having had their 4-year-old shots

- January 2005: DCF abuse report (Hotline call)
- February 2006: DCF abuse report (Hotline call)
- November 2006: Nubia has 9 excused school absences
- March 2007: DCF abuse report (Hotline call)
- April 2007: Nubia has 19 excused school absences
- April 2007: Nubia having academic difficulty due to court and psychological evaluation
- April 2007: Victor has 13 excused school absences
- May 2007: Victor has school psychological case opened
- May 2007: Guardian ad Litem objects in Court to continued placement of the children with the Barahonas (Court held hearing, found placement safe and appropriate. In addition, it is important to note that at some point during the pre-adoption period, the Guardian ad Litem was barred from the Barahona home due to inquiries made with the school. According to the DCF report, Guardian ad Litem was dismissed from the case to "smooth things over with the Barahonas.")
- June 2007: Children psychologically evaluated at request of Guardian ad Litem attorney, brought to evaluation by caregiver
- June 2007: During psychological evaluation, both children scored for depression, Nubia moderate, Victor mild, recommendation for individual therapy for each child, thoughts of suicide were evident and Nubia stated that she thought something terrible was going to happen to her
- September 2007: Victor and Nubia have to repeat first grade
- November 2007: Nubia has 6 school absences, 3 unexcused
- November 2007: Victor has 3 school absences, 2 unexcused
- December 2007: Case Manager unable to see the children in the home, Case Manager attempted two unannounced visits to the home after learning that the phone had been disconnected, children seen at school and no concerns for their safety noted. (In the DCF report there is reference that 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.)
- November 2008: Nubia has 7 unexcused school absences due to lice; caregiver's failure to provide medical documentation
- November 2008: Recommendation for updated medical examinations

- Supervisory review notes that "foster parent seems to have become less enthusiastic about providing documents timely"
- December 2008: Recommendations again that children need updated physical examinations
- January 2009: Nubia has 10 school absences year-to-date
- February 2009: Children still need updated physical examination
- March 2009: Children still need updated physical examination
- March 2009: Nubia has 13 school absences (11 excused) year-to-date
- March 2009: Decision made that if abuse reports found "no indicators" then no need to "staff" if no other concerns and if nothing else in file that indicates licensing violations then the cases do not need to go to committee
- May 2009: Adoption finalized
- Post-adoption/June 2009: DCF abuse report (Hotline call)
- Post-adoption/Summer 2009: Withdrawal from public school for homeschooling

Again we repeat, how could anyone have missed the looming disaster if they had read all of this information in one place and at one time? Even if someone was reading it over the course of time, at different intervals, patterns were still recognizable early on, and increasingly, as time went by. Immediately prior to the finalization of the adoption, alarm bells should have been going off for all to hear. Case Managers, with their newly imposed responsibility of owning the case, must forever be charged with the obligation of regularly reviewing all events in a case and recognizing the meaning of red flags such as these.

It might be said that many of the above events, if viewed separately, would indicate nothing. After all, no one is perfect, no parent and no foster parent. But the difference here is that each of these did not occur in a vacuum. Each of these events occurred in the lives of two very specific children, two children who were the subject of hotline calls and who ended up being victims in a system that should have been more aware of the suffering they endured.

VI. THE PRE-ADOPTION PROCESS

The Barahonas sought to become adoptive parents after they were licensed for years as foster parents. After obtaining their initial license they renewed the license for several years. Interestingly enough, DCF's website provides the following statement about persons seeking to become licensed foster parents in Florida:

> When we receive your application, we will review our records. If you have been investigated by the department in the past, you may not be eligible to become a foster parent.[13]

Had the same standard been applied to the Barahonas when they sought to obtain their initial foster parent license, they might not have been cleared. Had these reports and allegations been made about abuse committed by the Barahonas on their own children, DCF's Child Protective Investigators might have done a more exhaustive inquiry.

Florida's Explore Adoption[14] website provides the following information for Florida families who are seeking adoptions:

> Although the process may vary slightly depending on where you live, the road to adoption normally includes an orientation session, an in-depth training program to help you determine if adoption is right for you and your family, a home study and a background check. This process can usually be completed within less than nine months. Once the process has been completed, you are ready to be matched with a child…. The Model Approach to Partnership in Parenting (MAPP) is a ten-week training and preparation course that adoptive parents are required to successfully complete. . . . All of this information is gathered into a home study packet and sent for approval to an adoption specialist…. The purpose of the home study is to make sure you can provide a child with a safe and secure home. . . [15]

Florida's Explore Adoption website further provides that after the child is placed in the home, a counselor must make monthly visits in order to assess the child's adjustment and to determine whether new or additional services are needed. The supervision period ends when the counselor provides "Consents to Adopt" to one's attorney. Usually a child lives with the adoptive family for six months before the adoption is finalized.[16] It would appear that these practices do not apply when the adoption is being done by a foster parent and the child is already in the home.

The state's goal for its foster children is to find safe, permanent homes for them as soon as possible. Florida families adopted a record number of foster children in 2007-08, when 3,674 adoptions were successfully completed. Florida again set a record in 2008-09 with 3,777

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[13] http://www.dcf.state.fl.us/programs/fostercare/amiready.shtml

[14] "Explore Adoption," is a statewide adoption initiative aimed at promoting the benefits of public adoption and urging families to consider creating or expanding their families by adopting a child who is older, disabled or part of a sibling group. http://www.adoptflorida.org/about1.shtml

[15] http://www.adoptflorida.org/about2.shtml

[16] Id.

adoptions of children in foster care.[17] We wondered whether the goal of increasing the number of adoptions is at odds with the goal of ensuring the safety and security of the children in the foster care system. Are we in such a rush to get the children into a permanent placement that we are failing to take a long hard look at the persons seeking to adopt them? If the Barahonas had not served for so many years as foster parents would they have been subjected to more intense scrutiny as a result of the numerous calls to the Hotline? We appreciate, and applaud the efforts of all of the agencies and individuals who have been responsible for increasing the number of adoptions of foster children, however, we cannot be so driven by increasing those numbers that we end up taking children out of one hell-hole to simply place them in another one that has been sanctioned by the State of Florida.

A great deal of discussion was had about the psychological evaluations that were conducted of Nubia prior to her adoption by the Barahonas. We note that in the years prior to the adoption the Barahonas, after initially being approved to be foster parents, reapplied and were summarily approved each succeeding year. The subsequent approvals occurred even with the presence of several reports of alleged neglect and/or abuse. Notwithstanding the fact that the reports were not substantiated, we believe just the existence of so many reports within this time period required additional scrutiny of these foster parents. If the investigators had done an effective job, the cumulative impact of what they would have discovered was that the Barahonas failed to take Nubia or Victor for their regular doctor visits or dental checkups, they were neglecting the children by failing to feed them properly or see to their grooming and the Barahonas lied to the Case Manager and DCF regarding medical issues that were occurring with Nubia. When they sought to be re-licensed, a more detailed re-evaluation might have revealed that the Barahonas no longer qualified to serve as foster parents, especially for Special Needs children like Nubia and Victor.

More importantly, just as the children were given psychological evaluations before the adoption process was completed, we believe the Barahonas should also have received such evaluations. We received information that for some private adoptions, the entities processing the adoptions require that some prospective adoptive parents also submit to a psychological evaluation. Had such an examination been conducted in this case, it might have precluded the

[17] http://www.dcf.state.fl.us/initiatives/fostercare/docs/BecomingaFosterorAdoptiveParentFACTSHEET111909.pdf

adoption of Victor and Nubia by the Barahonas. It is pretty evident to us that at that time, they were not, if ever, fit to serve as foster parents, let alone, qualified to adopt a set of Special Needs twins. The sad irony here is that these two children were taken from their natural parents because of concerns of abuse and neglect, only to be placed in the care and custody of persons who neglected them and inflicted more abuse than their parents ever did.

We recommend that psychological evaluations be done of foster parents who seek to adopt children from Florida's Child Welfare System.

*We recommend that persons who have been approved and authorized to serve as foster parents be required to undergo a **full** re-licensure every two (2) years to ensure they still meet the criteria to serve as foster parents.*

We recommend that foster parents who are the subject of allegations of abuse or neglect of their wards be placed on some form of probationary status that requires more frequent visits and checks on the children in their care. We further recommend that any such probationary period be no less than six (6) months.

VII. THE POST-ADOPTION PROCESS

After the Barahonas completed the adoption of Victor and Nubia, they contacted DCF and advised that they no longer wished to serve as foster parents, claiming that their "family was now complete." It is apparent to this Grand Jury that one of the benefits of taking that position is it guaranteed that no more Guardian ad Litems or snooping Case Managers would be in and around the Barahona house. Coupled with the decision to pull the children out of public school, it also guaranteed that there would be fewer eyes observing the condition of the children. One of the most telling facts that corroborates this view is the fact that the Barahonas failed to request any "post-adoptive services" for themselves or for Nubia and Victor. Once Nubia and Victor were adopted, the Barahonas had a total of **three** (3) Special Needs[18] children in their custody. The local community-based care agency that assisted them in completing the adoption provides support such as information and referral services, support groups, adoption-related libraries, case management and training. To find out what options were available, all the Barahonas had to do

[18] "Special Needs" is a term used in federal rules to describe certain children eligible for financial assistance in the adoption process. It does not mean the child necessarily has a disability. In the state of Florida, one or more of the following criteria qualifies a child for Special Needs assistance: Age 8 or older; Member of a sibling group being placed for adoption together; African American or racially mixed; Significant emotional ties with foster parents or a relative caregiver; or Mental, physical or emotional handicap.
http://adoptflorida.org/about5.shtml

was talk with their adoption counselor or contact the Department of Children and Families' Regional Office. A review of the case file would have revealed that the Barahonas were not even keeping up with taking Victor and Nubia for their regularly scheduled medical visits. It defies logic that they would not (or did not) need assistance in meeting all of the other challenging present and future needs of these three young children. Had such services been provided, it would have afforded others not in the Barahona household an opportunity to observe these children. Such regular visits should have resulted in the earlier discovery of the physical abuse that the children were experiencing.

The unfortunate consequence of the Barahonas' failure to request the no-cost, post-adoptive services for these children is that they had made a conscious decision that services they knew these children needed (and should have been receiving) were not going to be available for these children. The fact that they were becoming the permanent parents of children with these needs and were not also providing the services needed to ensure their safety and security is just another form of neglect.

We recommend that DCF institute a new mandatory policy for all adoptive parents who adopt Special Needs Children. Any person who adopts a Special Needs Child will be required to receive services from the CBC Lead Agency or Full Case Management Agency that was previously assigned to that child. Post-adoptive services for Special Needs Children shall be provided for at least the first twelve (12) months after the adoption has been completed.

We recommend that prospective adoptive parents who do not agree to receive the minimum twelve (12) months of post-adoptive services for Special Needs Children be denied the opportunity to adopt such children.

VIII. WITHDRAWAL OF THE CHILDREN FROM SCHOOL

Throughout the Barahona chronology of events, there were numerous red flags that, had they been recognized as such, probably would have saved Nubia from death and Victor from torturous injury. The failure to recognize these red flags for the most part has been admitted by DCF and Our Kids and remedies have been implemented. DCF did what one would think is a comprehensive review of all of the problems highlighted by the Barahona tragedy. Those findings are included in a sixteen (16) page report with attachments detailing many of the issues that arose. For the most part, it is a comprehensive review with many remedies mandated in a very tight time frame. Our Kids, at the direction and insistence of DCF, put together a 12-page

Corrective Action Plan. While we applaud DCF and Our Kids for their critical self-reviews, we must point out a glaring absence: The failure to recognize the withdrawal from school as a red flag.

The DCF report on the Barahona case mentions, in its "Summary of Case History" specifically on page 4 the fact that subsequent to the closure of the Hotline referral about Nubia's unrelenting hunger and hair loss, that the children were voluntarily withdrawn from the public school system as the Barahonas intended to homeschool their children. There is no other mention of this anywhere in the report, no recognition of this as a red flag and of course, no implemented remedy.

The Our Kids Corrective Action Plan fails to mention this in any way. We recognize that Our Kids is not very involved in the post-adoption phase, except to offer post-adoption services. In fact, there is a section in its corrective plan about post-adoption services, but no mention of this particular issue as a potential red flag. Both agencies fail to mention this despite it having been pointed out as a glaring problem in The Nubia Report. Why was this ignored? Whatever reason it was not mentioned, we feel it is imperative that this issue be discussed in this report.

Homeschooling, or Home Education, as described by the Florida Department of Education website, is a "parent-directed educational option that satisfies the requirement for regular school attendance… Parents have the freedom to determine their child's educational path and the plan for reaching their goals. Students have the opportunity to explore and learn at their own pace, in any location or at any time." All of the Barahona adopted children were in our public school system, that is, until the Barahonas took out Victor and Nubia. The simple fact that the Barahonas left their other children in the public school system should have caused someone some discomfort.

The staff and personnel at the Miami-Dade County Public School System act as numerous sets of eyes to observe watch out for and ensure the well-being of our children. Sometimes teachers and school counselors are the frontline soldiers who often are the persons calling the Abuse Hotline to report bruises or swelling on little Johnny or Susie. They see these children every day and often times have more interaction with them than their parents. They are able to detect changes and problems affecting the children attending their schools. Such was the case here.

Nubia's teachers took note of her condition, and on two occasions, reported their observations to the DCF Hotline. After the June 9, 2010 call, and the only call post-adoption, (the adoption was finalized on May 29, 2009) the Barahonas removed **some** of their children (i.e., Victor and Nubia) from the public school system to homeschool them, thereby isolating Victor and Nubia from view and themselves from scrutiny. It should also be noted that the Barahonas had four adopted children. Only Nubia and Victor were the objects of the Barahonas abuse and torture. Only Nubia and Victor were the named children in the allegations of abuse. Only Nubia and Victor were withdrawn from school by the Barahonas. That factor should also have been a red-hot warning sign that something was terribly, terribly wrong.

We are not taking issue with the concept of homeschooling. We are taking issue with adoptive parents who, after having complaints lodged against them concerning the care of their adoptive children, after complaints not only post-adoption but pre-adoption as well, use homeschooling as a ruse to cover up their abuse of the children. This alone should have been enough of a red flag to have caused sufficient action to have kept these children in the public eye and maybe, just maybe, have saved the life of Nubia and protected Victor from the harm he suffered.

The procedure to establish a home education program, in other words to begin homeschooling one's child, is set out in Florida Statute 1002.41. It begins with the requirement to send a written notice of intent to the school district superintendent. The superintendent should be required to forward the Notice of Intent to DCF. We believe this would be the ideal moment at which a simple check should be made to determine whether there have been any abuse or neglect reports that would make the intent to homeschool a red flag. If there have been abuse or neglect complaints, the obligation to guarantee the safety of our community's children requires that an investigation be launched by DCF to make sure motives are pure and covert child abuse is not the true goal. Once that initial determination is made, a period of monitoring by DCF should follow to further ensure the safety of those children.

Therefore, we recommend that in instances where parents, adoptive or not, opt for homeschooling, that the statutorily required written notice of intent be forwarded to DCF to determine if any reports have been made to the DCF Hotline, whether ultimately founded or unfounded, substantiated or unsubstantiated, and, if so, be the immediate subject of investigation by DCF and a period of monitoring by DCF.

IX. CONCLUSION

For those agencies and persons involved in overseeing the children who end up in our foster care program, they cannot do an effective job if they do not have the whole picture. When you only have part of the whole picture, it is not possible to embark on the correct path to protect our children. We thought of the following.

The story of the blind men and an elephant is a story used to illustrate a range of truth and fallacies. It has provided insight into the inability to recognize truth or to come to accurate conclusions or to make the right choices based on partial information. It makes the point of explaining the behavior or action or, more importantly, inaction of some where there is a deficit or inaccessibility of information and the need for communication.

The story is a simple one. One version of the story goes as follows:

> Six blind men were asked to determine what an elephant looked like by feeling different parts of the elephant's body. The blind man who feels a leg says the elephant is like a pillar; the one who feels the tail says the elephant is like a rope; the one who feels the trunk says the elephant is like a tree branch; the one who feels the ear says the elephant is like a hand fan; the one who feels the belly says the elephant is like a wall; and the one who feels the tusk says the elephant is like a solid pipe.

Although each man was partly right, they were all wrong. In our Child Welfare System, there are those who have behaved like the blind people and the elephant. Each had part of the information, but not the whole. One cannot come to the right conclusion or embark on the proper approach to guarantee or ensure the safety of our children if one does not have the proverbial “full picture.”

To make matters much, much worse, in this case there was an utter failure to have the full picture **and** there was a persistent, insidious bias of trust. Here, these two factors combined to exponentially raise the risk of disaster. Murder was the result.

Let Nubia not have died in vain. Let us take these lessons to heart and implement solutions in a way to eliminate the bias of trust, to ensure the enlightenment gained from having the full picture and thereby better protect all children in the future.