IN THE CIRCUIT COURT OF THE ELEVENTH JUDICIAL CIRCUIT
OF FLORIDA IN AND FOR THE COUNTY OF MIAMI-DADE

FINAL REPORT
OF THE
MIAMI-DADE COUNTY GRAND JURY

FALL TERM A.D. 2013

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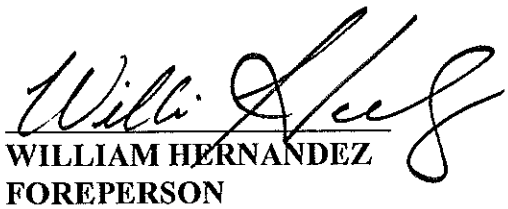

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FILED

June 24, 2014

Circuit Judge Presiding
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Continuing Nubia's Legacy: Follow-up to the Fall Term 2010 Grand Jury Final Report

I. INTRODUCTION

On July 25, 2011, the Fall Term A.D. 2010 Miami-Dade County Grand Jury released its Final Report entitled "*Nubia's Legacy: Confronting the Bias of Trust and Complacency in Florida's Child Welfare System*" (hereinafter referred to as the Nubia Report)[1]. The "Nubia" in the title is a reference to Nubia Barahona, a ten-year old girl who was repeatedly abused and ultimately killed by her foster parents who, prior to the time of the homicide, had actually adopted Nubia and her brother.

As reflected in the Nubia Report, the news stories of what happened to Nubia and her brother were "horrific". The information contained in the news reports, the First Degree Murder, Aggravated Child Abuse, and Child Neglect Indictments issued against the adoptive parents corroborated the Grand Jury's assessment that these children lived a "tortured existence" with the Barahonas. The purpose of that Grand Jury investigation and the primary reason for issuing its report and recommendations are found on page one of the Nubia Report:

> 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]

Sadly, child deaths and child abuse have both continued. In fact, during our term, we issued an indictment against a defendant for charges of First Degree Murder and Aggravated Child Abuse. In that case, the mother's paramour beat the two-year old child victim to death. Prior to the birth of that child, the mother had already lost parental rights to an older child due to her unfitness as a parent. The mother was arrested for Child Neglect with Great Bodily Harm

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[1] http://www.miamisao.com/publications/grand_jury/2000s/gj2010f.pdf

[2] *Nubia's Legacy: Confronting The Bias of Trust and Complacency in Florida's Child Welfare System*, p. 1, footnote 1.

and charged with Aggravated Manslaughter in connection with the death of her two-year old child. This Grand Jury decided to review the Nubia Report, examine the recommendations therein and determine whether Florida Department of Children and Families ("DCF") had implemented those recommendations.

Upon our review, we noted that many of the recommendations included in the Nubia Report dealt with three (3) specific areas: 1) Florida's Child Abuse Hotline (the "Hotline") and the Hotline Counselors; 2) the work and qualifications of DCF's Child Protective Investigators (the CPIs); and 3) technological upgrades and improvements to systems and databases used by DCF workers. This report will focus specifically on those three areas. Where relevant, and for convenience, we have included in each section below (as bulleted italicized entries) our predecessor's specific recommendations from the Nubia Report.

II. FLORIDA'S CHILD ABUSE HOTLINE COUNSELORS

The telephone number for Florida's Child Abuse Hotline is 1800 962-2873. The Hotline Call Center in Tallahassee answers all calls to that number, regardless of where they originate. Hotline Counselors are the front-line operators when it comes to identifying and protecting victims of child abuse and child neglect. They are the ones making inquiries of the callers, making assessments of callers' replies, all in an effort to determine whether the information meets the statutory criteria sufficient to forward a report to a Child Protective Investigator. Clearly, this is the most significant stage to the child protection process.

> 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. [3]

This was one of the shortcomings our predecessor Grand Jury saw in the Barahona case.

[3] Id. At p. 5

- *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.*

When a Hotline Counselor makes an inappropriate classification that leads to a delayed response time, the consequences can be tragic. Similarly, when a Hotline Counselor receives allegations during a call that reveal criminal acts are being inflicted on a child, the failure to make an immediate referral to law enforcement; or require an immediate response from a CPI, may result in a fatality. Our predecessors believed that more effective training for Hotline Counselors and their Supervisors on the classification of cases would help remedy this shortcoming. We are pleased to report that the "system process" improvement in this area is better than our predecessors could have ever imagined.

Consistent with the recommendations in the Nubia Report, all 171 Hotline Counselors have now received enhanced training. The enhanced training includes educating Counselors on what data to input in the system, what actions to take if a caller reports that an act of child abuse is "in process", and specific instructions on when and how to immediately direct and transfer such a caller to the local Sheriff's Office. The initial enhanced training, conducted in March and April 2011, was for improvements in the area of classification of cases. Thereafter, many of the call center training materials were updated and new policies were instituted. Now, for all reported crimes against children involving non-caretakers, the central abuse hotline immediately transfers electronically the report and the call to the appropriate county sheriff's office.

Additionally, in August 2011 DCF created a unit comprised of lead counselors who, among other things, would be available to take calls from investigative field staff regarding the possible escalation or re-classification of reports that Hotline Counselors have prepared. The Lead Counselors are also available when Hotline Counselors need assistance with screening decisions. More importantly, these lead counselors actively link all calls that come in when a decision is made **not** to initiate an investigation. The information provided by those callers is

input into the Florida Safe Family Network (FSFN) database and a case number is created. This process, and the creation of a case in the system of the "screened out" calls, allows for review of the decisions made by Hotline Counselors and also creates a record involving that specific child and/or family. This information will now be available to other Hotline Counselors in the event a subsequent call comes in involving the same family unit. Knowledge of the existence of the prior screened out calls might assist the Hotline Counselor in deciding whether to open an investigation based on a subsequent report of maltreatment involving the same child or family. Such data was not readily available pre-Barahona and that failing contributed to Nubia's death.

A. The Command Center

Another major improvement from the old process of initiating child abuse investigations is the creation of the Command Center. The Command Center is also located in Tallahassee and its function is to help better equip the CPIs who are assigned to handle child protective investigations. Under the old system, once the Hotline Counselor determined that statutory criteria was met, the information obtained from that call would be forwarded to the CPI in the DCF Regional office where the child resides. It would be up to the CPI to conduct any further background checks or database searches before beginning the investigation or proceeding to the location where the child was located. In a scenario where an "immediate" response is called for, performing this function may waste valuable time. That is not a problem anymore.

Now, when the Hotline Counselor determines that an investigation should be initiated the information obtained is forwarded to Counselors in the Command Center. Command Center Counselors have access to a number of databases that they can search using names, addresses, prior contacts, etc. The availability of that information allows the Command Center to create a big picture focus for the CPI. Even in scenarios where there have been several recent calls/complaints that were answered by different Hotline Counselors, that information (and the existence of those calls) now is available to the Command Center Counselor and included in the report sent to the CPI. One of the other benefits of having Command Center Counselors compile all available data into one report is the CPI now receives information that the CPI did not have access to and would not have been aware of in the past.

Counselors at Florida's Abuse Hotline strive to submit all reports to the appropriate DCF 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, depending on the classification, the investigator has up to 24 hours to initiate contact with the subjects of the report. In situations in which Counselors believe the victim is at imminent risk of harm, the investigator is required to respond as soon as possible. The work of the Command Center Counselors now allows the CPIs to respond in a more timely manner.

We are aware that various PowerPoint presentations have also been prepared to train Hotline and Command Center Counselors about changes in the law and how those laws affect the work of the Counselors. Many of these instructive training videos are on-line. Yet, even with the enhanced training, there was still a problem with ensuring that all available data was being collected by each and every counselor on each and every call. Under the old system, there was no set methodology for achieving this goal when handling hotline calls. If an experienced, eager and committed operator answered the call, then maybe all relevant questions would be asked and all pertinent information would be obtained. A call answered by an inexperienced and less enthusiastic operator would end up with the opposite result. Our review indicates that has changed.

B. Florida's Safety Decision Making Methodology

Prior to the Barahona incident, DCF did not have a set methodology for its Hotline Counselors when receiving calls or for its CPIs when conducting investigations. However, that has now changed. In late 2013, DCF adopted a Florida Safety Decision Making Methodology for use by its Hotline Counselors, Child Protective Investigators and other staff involved in child protection. The methodology, using a structured decision-making model, relies on pre-printed tools (forms) that are designed to assist the Hotline Counselor and Investigators in asking all the relevant questions, ferreting out all available information and determining a specific course of action based on the replies received, data collected and evidence obtained. Florida's Safety Decision Making Methodology is also available for use by CPIs when conducting their child maltreatment investigations. Use of the Safety Methodology should avoid future inappropriate classifications and will assist DCF staff at all stages of the child protection process in making informed decisions and taking appropriate and timely investigative steps.

III. THE CHILD PROTECTIVE INVESTIGATORS ("CPIs")

Child Protective Investigators are responsible for conducting investigations of child maltreatment allegations that Hotline Counselors determine meet statutory criteria for intervention by DCF. The cases may involve child abuse, abandonment, or neglect. We believe one of the most challenging jobs at DCF is that of the Child Protective Investigator. These investigators are usually DCF's first contact with the families and children who are the subjects, suspects and/or victims in child maltreatment cases. Performing their jobs well requires many different skill sets.

Like law enforcement officers, CPIs get to see people at their worst. They are exposed to people in places and under conditions that most of us could never imagine. Upon making observations of living conditions and conducting an appropriate investigation and assessment of the family unit, the CPI is then required to determine whether leaving the child in that environment creates a safety issue for the child. If there is a safety threat, is it sufficient to justify removing the child from the home? Any errors in judgment may result in a child's death or serious bodily injury.

According to information on the State's website,[4] the minimum eligibility requirements for the CPI position is a Bachelor's degree from an Accredited College or University, possession of a current valid State of Florida driver's license; and two (2) years of child welfare related experience. Higher education may substitute for the child welfare experience. At the time our predecessors released their report, the starting annual salary for this position was $32,000. It was recently increased to $39,000. That salary is outrageously low for the duties, responsibilities and demands placed on the persons who serve in these positions. To give one an appreciation of the great disparity that exists between the duties and the dollars we have cut and pasted below (from the state's website) the People's First job posting announcement for the CPI position:

[4]People's First State of Florida, HR https://jobs.myflorida.com/viewjob.html?optlink-view=view 707172&ERFormID=newjoblist&ERFormCode=any

EXAMPLE OF WORK

Respond to reports of child abuse & neglect from the Florida Abuse Hotline
Investigate allegations of child abuse & neglect
Make assessments of family situations and determine if a child is safe in the home
Offer community resources and services to children & families
Remove children from their homes in cases of severe or egregious abuse
Maintain electronic case management files
Perform on-call duties

KNOWLEDGE, SKILLS AND ABILITIES:

Ability to identify problems, determine accuracy and relevance of information, use sound judgment to generate and evaluate alternatives, and make recommendations
Ability to manage and resolve conflicts, grievances, confrontations or disagreements in a constructive manner to minimize negative personal impact
Ability to display high standards of ethical conduct
Ability to weigh the relative costs and benefits of a potential action to make sound decisions
Ability to maintain composure and perform effectively under stressful conditions
Ability to leverage available information, even if all the facts are not provided to make the best decision possible
Ability to adjust ones actions in relation to other's actions
Ability to manage one's time and the time of others
Knowledge of principles and processes for providing excellent customer service
Knowledge of theories and practice in child protection
Knowledge of professional ethics relating to child protection and counseling
Knowledge of family-centered interviewing and counseling techniques
Knowledge of investigative techniques
Knowledge of interviewing and observation techniques
Skilled in considering child development in guiding placement of children
Ability to conduct risk and safety investigations
Ability to plan, organize and coordinate work assignments
Ability to understand and apply relevant laws, regulations, policies and procedures
Ability to actively listen to others
Ability to communicate effectively
Ability to maintain well-executed case files
Ability to establish and maintain effective working relationships with others
Ability to utilize complex computer systems
Ability to write clear and accurate investigative reports

The CPIs presently performing the aforementioned duties do so while driving in their personal vehicles to the various homes, hospitals and other locations they are required to visit. There was little or no upward mobility for employees filling the CPI position. Not surprisingly, we understand that job attrition is a regular problem for DCF in keeping these positions filled. Sometimes the attrition rate soars in connection with bad press or publicity regarding mishandling of a high-profile case or a major failing of DCF. In fact, we were advised that over a 3-4 month period after the release of the information regarding the Barahona case, forty percent (40%) of all the state's CPIs resigned from their position. However, we understand that now,

many of the former CPIs who left are returning to the agency. We believe this is a direct result of the career path that was created as a result of new job positions created by the Florida Legislature.[5] We also believe the creation of this new career path will assist in retaining experienced CPIs.

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

Our predecessors' believed that DCF should create a preference for hiring CPIs whose background, education and experience where more directly related to law enforcement as opposed to social work. Although DCF made such a request during the 2014 Legislative session, the Florida Legislature actually went in the opposite direction. In 2014 Legislators passed legislation which supported the hiring of new employees from social work professions as opposed to criminal justice related professions.

However, even before that decision was made DCF tried to respond to the law enforcement recommendation in the Nubia Report. DCF decided to integrate successful law enforcement business practices in its training of CPIs and the CPI Supervisors who perform in the field. Specifically, DCF developed and provided to all CPIs two training curriculums in 2011. The trainings were 1) Investigatory Interview Technique Training (which assists the CPIs when speaking to victims, witnesses and potential subjects); and 2) Presentation of Evidence in Court Training (which assists the CPIs whenever they have to testify in a court setting). These training programs have been incorporated into and included in the CPI pre-service training for all new CPIs.

Finally, DCF is also affirmatively seeking CPI and CPI Supervisor applicants who have advanced degrees, more academic achievement and a broader range of work history and experience. With DCF's present CPI workforce the most common educational degree for investigators is a Bachelor of Science Degree in Criminal Justice. We believe this additional experience and focus on those with criminal justice backgrounds will result in more effective and thorough investigations.

1. *We recommend that all CPI applicants receive and pass a Behavioral Assessment Test as part of the application process.*

[5] The career path moves from CPI, to Senior CPI, to Field Consultant to CPI Supervisor.

- *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.*

All DCF Regional and local offices and all CPIs now have the authority (and the responsibility) to reassess, reevaluate and reclassify all reports and response times in cases sent by the Hotline alleging child maltreatment. Further, due to a change to the law in 2012, when CPIs receive their initial reports from the Call Center, they are now **required** to review the reports to determine if immediate consultation with law enforcement is needed and/or whether it is necessary for law enforcement to accompany the CPIs when they make their home visit.

A. CHILD PROTECTIVE SERVICES ("CPS") INVESTIGATIONS PRE-BARAHONA: A TALE OF TWO CPIs

There is a marked difference between the practices and procedures Child Protective Investigators employed pre-Barahona and the manner in which they conduct CPS investigations now. Pre-Barahona the CPIs would obtain an incomplete packet of information, one that basically only included the information obtained by the Hotline Counselor. There was no big picture view of the family available to the CPIs. The Investigators did not have information about prior contact between the family unit and DCF, nor did they have any criminal history information on the persons who may have been responsible for the alleged maltreatment. Although the information was available in several data bases, the CPIs would have to conduct the searches themselves to acquire the information. Upon receiving a new case of possible maltreatment from the Hotline Center which required an "immediate response, the CPI would have to ask a crucial question: What should be done first, searching for background data or making contact with the family to ensure the safety of the child?

1. CPS Investigations: An Incident Focused Approach

Regardless of which option was employed, eventually the CPI would make contact with the family. At that point there appear to be two (2) types of CPIs. First, there were the incident focused CPIs. These CPIs saw their role very narrowly; to determine whether, in accordance with what was in the report, any maltreatment had been inflicted on the child(ren) in question. If there was no evidence (or insufficient evidence), of maltreatment, their job assignment was over,

their work was complete and the complaint was deemed "unfounded" or not verified. Very often, these decisions were made on cases involving families with a significant number of prior child protective referrals. That was how incident focused CPIs performed their job.

2. CPS Investigations: A Comprehensive Approach

However, a different type of CPI was also working at DCF during the pre-Barahona time frame. These CPIs could respond to the same family, investigate the same allegations, reach the same conclusions as the "incident focused" CPIs but would not view the assignment as complete. Instead, these CPIs would spend time with families. They would assess fully the family dynamics and functioning and more appropriately identify and align treatment services for that family unit. They would also try to determine whether there were underlying issues that might have led someone to make a call to the abuse hotline. If the conversations and additional time spent with the family revealed a family that was in need of services, the CPI would then determine what services were needed, what services were available and make referrals to the family so they could receive those services. The intervention and provision of services might serve to prevent any further problems with the family, could preclude subsequent child protection referrals and prevent any future maltreatment or death of the child(ren). Studies and research corroborate these results for Child Protective Services Investigations that encompass a comprehensive approach. For instance, one study found that prior in-home services reduces a child's odds of death by 90%.[6] On the other hand, the results from short-sighted incident focused investigations are painfully revealed in a report issued by Casey Family Programs[7] to DCF in October, 2013.

B. The Casey Family Programs Report

In October 2013 Casey Family Programs released a report entitled *Review of Child Fatalities Reported to the Florida Department of Children and Families.*[8] The review stemmed from a DCF request that Casey Family Programs (CFP) review summaries of recent child fatalities completed by DCF Quality Assurance staff. DCF's Quality Assurance (QA) staff

[6]North Highland, The Child Welfare Policy & Practice Group, Child Fatality Trend Analysis, January 1, 2007 through June 30, 2013, Executive Summary, November 27, 2013.

[7] Casey Family Programs is the nation's largest operating foundation focused entirely on foster care and improving the child welfare system.

8 http://centerforchildwelfare2.fmhi.usf.edu/qa/ChildFatalities/CaseyRevOfChFatalities2013.pdf

review case files after-the-fact, when there is a child fatality. The child fatalities reviewed by CFP in the report related to child maltreatment complaints received by DCF during the first seven months of 2013. The QA summaries provided information regarding the circumstances and events that led to each child's death, as well as brief accounts of prior child protective services reports and investigations. DCF managers chose the specific cases they wanted CFP to examine and intentionally chose cases with the most complex dynamics and history.

1. The Incident Focused Approach Does Not Work

The purpose for CFP's review of the child fatality reviews was to provide DCF leadership with feedback on Florida's child protection practices as described in the summaries and to offer recommendations regarding policies and practices that could potentially reduce further child maltreatment deaths. The following findings and quotes from the CFP Report are reflective of the shortcomings and tragic results that can ensue from CPIs operating solely from an incident focused perspective.

> Assessments of safety during previous [Child Protective Services] CPS investigations of families of children who subsequently died were usually narrowly focused on the **reported allegations in the most recent report. These safety assessments often did not** appear to consider the family's prior CPS history or to explore domestic violence, substance abuse and other family dynamics which increase risk to vulnerable children.[9]

> "While the cause of the child's death was not related to any of the ... prior child protection activities with this family, these prior investigations provided ample opportunity for assessment and services to be brought into the home which may ultimately have prevented this child's death. Domestic violence and substance abuse dynamics were woefully underexplored. ... The overall thoroughness of the investigations leading up to the child's death is highly questionable." [10]

> "...overall, the relevance of prior history was not taken into full account during this investigation. . ."[11]

[9] Casey Family Programs, *Review of Child Fatalities Reported to the Florida Department of Children and Families* October, 2013, p. 4
[10] Id., pp. 4-5
[11] Id., p. 5

> "It does not appear the prior history of this mother was thoroughly used" and the QA reviewer added "The prior history of families' needs to be taken into account when completing assessments ... and not solely looking at the isolated incident of the case."[12]
>
> A history of multiple CPS reports was sometimes minimized even when children in the family had suffered extreme harm. In one case with 37 prior CPS reports, a 3 year old child had almost died from severe malnutrition when she was a baby, and the parents had attempted to trade another of their children for housing. According to the QA reviewer, "it does not appear that these (priors) were taken into account in this investigation."[13]

The Casey Family Programs findings above and the quotes from the Quality Assurance staff summaries reveal a consistent pattern of certain CPIs failing to take into account prior child protective services investigations and ignoring risk factors not related to the maltreatment allegation they were investigating. Sadly, and regrettably, each of these failures in assessment resulted in a child fatality.

C. Child Protective Services Investigations Post-Barahona: Structured Decision Making

With DCF's new policies, practices and procedures in place Child Protective Investigators can no longer perform perfunctory incident focused investigations. In fact, at the Regional level here in Miami-Dade County the entire process for CPIs responding to allegations of maltreatment of children has been totally revamped. For two years now, CPIs here have been using the structured decision making model for handling their investigations. In addition, there are many new procedures that take place before the CPIs makes their first contact with the family. These procedures ensure that the CPIs are aware of any prior history of child protective services investigations, that they consider the impact of that history and that they factor that history into the strategy they will use in conducting the current investigation.

[12] Id.
[13] Id.

1. The Receiving Unit

For children who live in Miami-Dade County, the Receiving Unit at the Regional Office, sometimes referred to as the Analytic Unit, is the department that receives reports of maltreatment from the Command Center. Now, upon receipt of the more robust packets of information, employees in the Analytic Unit begin requesting and acquiring all types of additional information that will be used by the CPI to develop a broad assessment of the family unit. This additional information will assist the CPI during the next sixty (60) days in which the investigation will be open. With knowledge of the address of the child's location, the Analytic Unit contacts the local police department and requests information on all "call outs". The "call outs" represent history for any and all instances where the police were called out to that address. The call outs will reveal the reason(s) why the police were dispatched to that location. Such information may prove to be relevant to the CPI in his/her assessment of that family's problems and or needs. For instance, prior reports of domestic violence or drug use, even if there were no arrests, should raise red flags for the CPI.

The Analytic Unit will also run a local CJIS (Criminal Justice Information Systems) search to determine whether any members of the family unit have any local past or pending court cases in the civil, criminal, family or juvenile divisions. Staff in the Analytic Unit is looking to see whether there are any trends or patterns beyond the allegations set forth in the newly received maltreatment complaint. Using the *Our Florida* website the analytic employees can run additional searches so that the CPIs will have the broadest view possible of the family unit they are about to encounter.

2. Paired CPIs: A Team Approach

One of the most innovative developments with CPIs concerns a pilot project that DCF is presently conducting in Orlando and Miami. Under the pilot project here in Miami, a paired group of CPIs will be sent out on maltreatment complaints if the allegations and circumstances meet certain criteria. The plan is to use a team approach when there are specific risk factors present that increase the odds of a child's death. Paired CPIs will be sent out for maltreatment allegations if the child is three years old or younger, if there has been any prior history of

maltreatment, if the family has any prior history involving domestic violence, drug or alcohol abuse, or if one of the parents (as a child) was the victim of a child maltreatment allegation.

Sometimes the pairing is simply sending a more experienced CPI with a less experienced one. Alternatively, the pairing may be based on the needs of the family. For instance, depending on the nationality of the family there may be a need to send a CPI who speaks a specific language. Often times, injured victims of maltreatment may be getting medical treatment at a hospital. In that situation using a second CPI allows for a more expedient investigation; one CPI can be dispatched to the hospital to meet with the child while the other can deal with the parents, guardians or other family members. Utilizing the team approach provides a second set of eyes, allows for collaboration among the CPIs, results in a more extensive assessment and fosters a team approach when it is time to create an appropriate safety plan. Setting up a system where paired CPIs could be sent out has a side benefit of creating mentors for the less experienced CPIs. Such a program also provides an opportunity for younger CPIs to learn from experienced CPIs who have "been there and done that."

The Paired CPI pilot program began at the end of August (with training). DCF implemented the program in the beginning of September 2013. Since then, local DCF has sent out a paired response team on more than 100 cases where the eligibility criteria were met. Unfortunately, in far too many cases where eligibility was also present, there was not enough available staffing to send out paired CPIs. During Florida's most recent legislative session we understand that DCF requested additional FTEs to hire more CPIs so that when certain criteria were met Paired CPIs could be utilized. We understand that although the legislature provided funding for an additional 120 FTEs for CPIs this specific request was not granted, due to other funding obligations. However, due to the tremendous benefits that we believe would ensue from greater utilization of this team approach on specified cases:

We recommend that DCF conduct an evaluation of the pilot projects to determine whether there has been a decrease in the attrition if its CPIs and an increase in the quality of the investigations being conducted by CPIs utilizing the Paired CPI model.

If the evaluation reveals that the Paired CIP model is successful, we recommend that the Legislature provide funding and sufficient FTEs to replicate this model for the rest of the State of Florida.

3. The Pre-commencement Conference

- *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.*

Once the Receiving Unit has obtained all of the data, a full packet of information is given to the CPI who will be assigned to handle the investigation. However, the CPI is not yet ready to head out for the home visit. Instead, the next step is the pre-commencement conference; a meeting between the CPI and the CPI's Supervisor (the "CPIS"). Pre-commencement conferences began in 2013 at one of the centers in DCF's Regional Office in Miami-Dade County. The conferences are now mandatory throughout the state. At the pre-commencement conference the CPIS and the CPI review all of the background information obtained to-date, engage in critical thinking and strategize on what would be the best approach for the CPI to take in engaging with this particular family unit. Participants in the meeting also determine whether a law enforcement officer should accompany the CPI on the visit to the child's home.

One of the specific things discussed at the pre-commencement conference is risk factors that may be present with the family unit or with the child who may be the victim of maltreatment. Evidence of risk factors may be present in prior Child Protective Services reports. Research and studies have revealed that with many child maltreatment deaths there are common baseline risk factors. The risk factors include things like prior removals of a child from a home due to sexual abuse, physical abuse, parent drug or alcohol abuse, or child drug or alcohol abuse. Other risk factors not related to prior removals include a physical disability of a child and the age of the child. The presence of either or some combination of these risk factors increases the odds that a child will die if left within that environment, particularly if services are not provided to that family.[14] The use of the pre-commencement conference serves a great purpose in creating a team approach to examining the situation, assessing risk factors from the background material and strategizing on the plan that should be used when the CPI makes contact with the family. Utilization of this pre-commencement process allows the junior CPI to learn investigative tools and techniques from the seasoned, more experienced supervisor.

[14] *See* - North Highland, The Child Welfare Policy & Practice Group, Child Fatality Trend Analysis, January 1, 2007 through June 30, 2013, Executive Summary, November 27, 2013.

As the referral of cases from the hotline occur "24/7", it is not uncommon for the next CPI on the rotation to be assigned a case late at night, on weekends or in the wee hours of the morning. When that happens on cases that require an immediate response, in lieu of a face-to-face meeting with the supervisor the CPI conducts the pre-commencement conference over the phone. All of this preparation work is done in an effort to provide the best investigation and the best benefit for the family.

4. The Home Visit

At this point, all of the preliminaries have been addressed. The Analytic Unit received the packet from the Command Center, conducted its additional research and background checks and compiled all of the information. The complete packet of information has now been delivered to the CPI for review. The determination has been made whether this particular scenario meets the criteria for sending the paired CPIs, and if such is the case, the Supervisor has held the pre-commencement meeting with the CPIs, analyzed all of the data and developed a strategy for how the CPIs should handle the investigation of this particular allegation of maltreatment. Now is the time for the CPI to make contact with the child and the family.

Upon arrival at the home CPIs will investigate the specific allegations in the child maltreatment report. This is accomplished primarily with extensive interviews and interactions with the caregivers and the child who is the subject of the report. The CPIs will use the information gathered during this process to conduct their assessments at the home.

Because this is a critical step of the investigation process, we are encouraged that DCF has adopted the Florida Decision Making Methodology. The Florida Safety Model was developed by DCF in consultation with the National Resource Center for Child Protective Services (NRCCPS) and the Children's Research Center (CRC). The model is designed to identify children in present danger or impending danger and to assist staff in deciding, among other things, whether in–home safety plans can sufficiently protect children identified as unsafe. The Safety Model employs three specific assessment tools.[15] They are the Child Present Danger

[15] A copy of each tool is attached hereto as Composite Exhibit A-1, A-2 and A-3.

Assessment (PDA); the Family Functioning Assessment (FFA)[16]; and the Family (Household) Risk Assessment of Child Abuse and Neglect.[17] All three (3) tools are prepared after the CPIs conduct their interviews at the home. Each tool serves a different purpose. For instance, with the Family Functioning Assessment (Composite Exhibit A-2) the CPIs are required to examine and analyze every "domain" of the assessment tool regardless of the nature of the reported incident or complaint. Again, an incident-focused approach is no longer an option. In order to complete the Family Functioning Assessment, the CPIs will gather information in five key critical domains:

- the maltreatment that occurred and the circumstances surrounding the maltreatment;
- child functioning;
- adult functioning;
- parenting practices (including discipline);
- parental/ legal guardian protective capacity analysis;

Specialized training is required before the CPIs are able to use these forms.

The assessment tools work hand-in-hand with the science of predictive analytics.[18] Several entities have conducted independent evaluations and examination of DCF files and data related to child abuse/neglect cases that support these findings. Many of these cases reviewed involved child fatalities. Following its analysis, each entity released a report. One such report specifically looked at common risk factors that were present in many of Florida's "child maltreatment" death cases that occurred from January 1, 2007 through June 30, 2013.[19] Several baseline risk factors identified in the Casey Family Programs report include, among other things, the age of the child, the number of prior allegations of Child Maltreatment, and prior removal of a child from the home.

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[16] The Family Functioning Assessment is a comprehensive assessment tool intended to gauge safety threats termed "impending danger". The FFA leads the CPI to assess a number of issues related to parent/guardian protective capacities (the ability to protect the child from harm).

[17] The Family (Household) Risk Assessment incorporates two separate scales to assess risk for abuse and risk for neglect, with an overall risk level determined on the basis of the highest score between the two scales. The overall risk score is used to classify families according to risk level category (Low; Moderate; High; Very High) and is intended to guide referrals and service levels following the close of an investigation.

[18] Predictive analytics is the practice of extracting information from existing data sets in order to determine patterns and predict future outcomes and trends. Predictive analytics does not tell you what will happen in the future. It forecasts what might happen in the future with an acceptable level of reliability, and includes what-if scenarios and risk assessment. http://www.webopedia.com/TERM/P/predictive_analytics.html

[19] Casey Family Programs, *Review of Child Fatalities Reported to the Florida Department of Children and Families* October, 2013

Based on analysis of the data, for each baseline risk factor identified, researchers have assigned an estimate of how much a child's odds of death are increased or decreased by that specific risk factor. The significance of a particular risk factor assessment also could be impacted by the category of death, i.e. whether it was due to Abuse, Drowning or Asphyxiation.[20] We will review some of the risk factors below.

In many cases, DCF provided in-home services to the family before a fatality or serious injury occurred. As a risk factor:

- "Total prior in home services" **reduced** a child's odds of death by 90 %. Although this was observed in deaths involving Abuse and Drowning, it was not significant in the Asphyxiation category.
- Each instance of a **prior removal** of a child from a home **due to physical abuse increases the odds of death by a multiple of 14**. Here, the effect was observed in deaths in the Abuse category, but it was not statistically significant in the Asphyxiation and Drowning categories.
- Each **prior removal** of a child due to parents who have abused alcohol or drugs **increases the odds of death by a multiple of nearly 15**. This effect was strongest in the Asphyxiation category, followed by the Drowning category. Though still statistically significant it exhibited less of an effect in the Abuse category.

There was one risk factor that had an "across the board" effect. It was the age of the child.

- Seventy-five percent (75%) of all child deaths were between 0 and 2 years of age. Although the effect was observed across the board its impact was strongest in the Asphyxiation category.
- In the study, the top two causes of death for children 0-4 years of age were unsafe sleeping and drowning.

With this scientific data, experts crafted another tool, the Family (Household) Risk Assessment of Child Abuse/ Neglect. This tool is also completed after the CPIs conduct their home interviews. As reflected on the Risk Assessment form (Composite Exhibit A-3) CPIs consider a specific list of parameters depending on whether the complaint being investigated

[20] The definitions used for the three (3) categories are as follows:
Physical Abuse – Abuse of a physical nature inflicted on a child that results in serious bodily injury or death.
Drowning – Includes deaths of children who drowned in bath tubs, swimming pools or ponds.
Asphyxiation – With child fatalities it usually refers to unsafe or co-sleeping arrangements where suffocation occurs when an adult or older sibling sleeping in the same bed rolls over onto the child and suffocates the child, or the child is placed face down on mattresses, or placed in cribs with pillows, comforters or other soft objects.

involves allegations of neglect, abuse or both. Among other things, the CPI determines: 1) whether there have been prior investigations, and if so, what types; 2) whether the household has previously received ongoing child protective services; 3) the age of the youngest child in the house; and 4) whether the primary caregiver has any historic or current alcohol or drug problem. Each baseline risk factor is given a numerical value. Once all risk factors have been assessed the CPI calculates the Total Neglect Risk Score and/or Total Abuse Risk Score and uses that number to determine the Scored Risk Level. The four scored risk levels are low, moderate, high and very high. Through evaluation of additional criteria and assignment of additional numerical values, using the Florida Safety Decision Making Methodology tool the CPI obtains a Final Risk Level.

Once all three tools are completed the CPIs are better able to determine whether the child is at risk, and if so, can the CPIs craft a viable safety plan.

The third safety methodology tool that the CPIs will prepare at the home is the Child Present Danger Assessment Form (Composite Exhibit A-1). As is indicated by its title, this form is designed to assist the CPI assessing any present danger that may exist for the child in that environment. With a series of questions that must be answered by the CPI, the tool forces the investigators to focus on specific threats that may be present in that home, for that particular child(ren), and from that child's parent, guardian or caregiver.

Starting in 2013 and continuing into 2014 all CPIs in the State of Florida are receiving training on the Safety Methodology and the effective use of these investigative tools. Presently, approximately 85% of all DCF staff in Florida has received training on the Safety Decision Making Methodology. DCF expects full implementation of the Florida Safety Decision Making Methodology by August 2014. We believe this is a huge step in the right direction that should reduce the number of preventable child deaths in Florida.

5. Removal of the Child vs. Leaving the Child in the Home

Once the CPI has made contact with the child, the family and possibly others who may have information regarding the allegations, the CPI is then faced with making a decision. The Investigator has to determine whether leaving the child/children in that house and /or in that environment will place the child/children at risk for harm or abuse. If the Investigator decides to move the child/children from the home a hearing will be scheduled and conducted within hours. At that hearing, the CPI will have to present sufficient evidence to convince the Judge that

removal of the child/children was appropriate. If the evidence is insufficient, the court could order the return of the child/children to the home. If the CPI determines that the removal of the child/children from the home is not required or necessary, while at the scene the CPI will create a safety plan. The safety plan is a plan for keeping the child/children in the house until DCF can figure out what services are available and can be provided to the child and or family. Of course, this is a critical stage in the process. If the CPI makes an error in judgment at this point, the potential in his /her assessment for disaster is ever present. If the CPI has miscalculated the risk of danger to the child/children, the result could be the death of that child.

6. Safety Plans – Trust, But Verify

If CPIs determine that a "danger threat" is present, they must proceed to implement action of a Safety Plan and conduct an In-Home Safety Analysis. Very often, in the past, the safety plans were only safe if the parents or guardians did what they promised to do. For instance, a drug abusing parent "promised" to stop using drugs or a co-sleeping parent "promised" not to sleep in the same bed with an infant. If they made empty promises as a means of preventing removal of their child(ren), and never had any intentions of honoring what the safety plan required, the children were being placed in harm's way. This was especially so in cases where the CPIs trusted, but did not verify that the parents or guardians were keeping their end of the bargain. In many instances, something as simple as making a return visit to the home was not done.

a) Casey Family Programs, Review of Child Fatalities

One of the major criticisms in the Casey Family Programs report on child fatalities dealt with this area of Safety Planning. To highlight some of the major failings in this area, we have listed below several quotes from that report: [21]

> In many CPS investigations prior to a child's death, an in-home safety plan appeared to be clearly warranted. However, no safety plans were developed in a number of these cases. Completed safety plans were usually not adequate to control safety threats to children in that they were inadequately resourced and highly dependent on parents' promises. In most cases, CPIs did not follow up on safety plans to assess their effectiveness.

[21] Casey Family Programs Report, p. 6

In some cases, the CPI did not adequately assess or address the safety of other children in the household following a suspicious child death. Assessment and decision making processes regarding sibling safety appeared highly variable and unstructured.

In-home safety plans were used infrequently during investigations which occurred prior to a child's death, possibly because CPIs viewed children as safe despite multiple risk factors, or because of the narrow focus on specific incidents as notes above, or possibly because of a lack of confidence in safety plans.

With few exceptions, in-home safety plans did not utilize resources or safety management services such as child care, respite care, safety networks, poverty-related services or home visitors. As a consequence most in-home safety plans were incommensurate with the safety threats they attempted to control or ameliorate.

However, the single most questionable practice in the use of in-home safety plans was the lack of follow-up by CPIs to evaluate child safety and to assess whether parents were keeping their promises.

The findings and observations contained in the Casey Family Report clearly reflect that the failure to create effective safety plans and the failure of CPIs to follow-up for compliance with parents and caregivers on safety plans contributed to the deaths of the very children DCF was supposed to be protecting. However, as bad as this aspect of Child Protective Services investigations has been, we join the Casey Family Program Report in its assessment that the new Florida Safety Methodology that DCF is in the process of developing appears well designed to address many of the problematic child protection practices identified in (its) review.

D. The Quality Assurance Unit

Although the Legislature did not approve the funding request for the Paired CPIs Proposal, the Legislature did provide funding to create a Pilot Program for an enhanced Quality Assurance (QA) Unit. Presently, DCF QA staff, among other things, prepare child fatality review summaries in cases where there is possible child maltreatment. Obviously, this review only takes place **after** a child has died. At that point QA reviewers provide factual information regarding the circumstances and events that led to a child's death and include brief accounts of prior child protective services reports and investigations. QA reviewers conduct an analysis of the prior investigations, determine the appropriateness of safety plans and essentially try to

conclude whether there is anything that DCF or the Case Managers could have, or should have done. Findings are shared and discussed so that the Agency can learn from its mistakes.

As a result of legislative funding the Quality Assurance units presently in place around the state will be enhanced with the addition of an additional twenty-six (26) DCF employees. The purpose of these additional Quality Assurance employees is to have seasoned investigators who provide a safety check process and review DCFs actions, investigations and recommendations and procedures implemented on randomly selected **open** investigations. The members of the Unit will provide real–time quality assurance. Planning began in November 2013 with actual implementation beginning in January 2014.

For these 26 new employees, QA staff will be assigned to review cases that 1) have been open 25-35 days; 2) involve children three (3) years or younger; and 3) have a risk factor of substance abuse, mental health or domestic violence. They will review the files not just to see whether CPIs fulfilled all tasks on a check list. They will be looking to see whether any critical things were overlooked or whether there were any inappropriate, improper or insufficient actions taken by DCF on the specific case being reviewed. Following review of the case file by QA staff, meetings are scheduled with the CPI, the CPI Supervisor and the QA staff to discuss safety plans, risk assessments and any other relevant or questionable actions taken with regards to the investigation.

In addition to being a safety check, the Quality Assurance Unit can also be used to enhance the training of CPIs by identifying repeated errors or omissions committed by the Investigators. The quality checks can also serve as a way to measure or confirm the effectiveness of the CPI training by noting appropriate and necessary actions that were taken and implemented by the Investigators. We recognize that a total of twenty-six total Quality Assurance employees for a state the size of Florida and for an agency that deals with massive numbers of allegations and investigations is woefully inadequate. However, we view it as a step in the right direction.

The Grand Jury believes that the Legislature's decision to give DCF 26 new FTEs, for enhancement of the Quality Assurance Unit was a good decision. Upon proof of the effectiveness of that Unit during the Pilot project:

We recommend that the Florida Legislature, at a minimum, consider doubling the number of FTEs dedicated to enhancing the operation of the Quality Assurance Unit with review of open CPI investigations.

We recommend that DCF use any additional Quality Assurance Unit FTEs to deploy Quality Assurance personnel to those regions of the State that are not presently receiving such real-time review of open child protective investigation cases.

E. CPI Caseloads

One of the concerns of our predecessors and one that we share is the caseload of the CPIs. As we delineated on page 7 herein, the CPIs have an enormous responsibility and a great number of duties that they must perform if they are to do their jobs effectively. Their supervisors expect that the cases they are assigned will be closed within sixty (60) days. In fact, any case that remains open past fifty (50) days requires a meeting where the CPI has to explain why the investigation has not yet been closed. So, in essence the CPIs have a rolling, ever-changing caseload with the number of cases remaining pretty constant as old cases are closed and new cases come in. Attrition of the CPIs only add to the problem.

Each resignation of a CPI increases the caseloads of the remaining CPIs. An existing caseload from a CPI cannot be given to an inexperienced new-hire. Clearly the most difficult and challenging cases are assigned to the more experienced CPIs. This too becomes problematic with decreasing numbers of seasoned Investigators. We are pleased to report that the Florida Legislature has listened to some of the pleas from DCF and has given DCF additional money and F.T.E positions as well as created new job titles. We believe these improvements should assist with the present state of affairs of DCF's Child Protective Investigators and should permit DCF to retain more of its seasoned CPIs and CPI Supervisors. Specifically, we give thanks to the Florida Legislature for the specific grants of full-time equivalent positions and funding increases that allowed DCF to:

- Raise the CPI starting annual salary from $32,000.00 to $39,000.00
- Create a career track for CPIs
- Create a new title and position of CPI Supervisor
- Create a new title and position of CPI Field Consultant
- Raise the salary of experienced CPIs
- Hire 110 additional CPIs

- Begin a pilot program with twenty-six Investigators, who will participate in a state-wide quality assurance role on open cases

We believe the impact of these improvements will slow the rate of attrition for CPIs, and thereby, help address the caseload problem.

Pre-Barahona, CPIs were carrying, on average, a caseload of 20-30 open cases at a time. The information that we received revealed that the recommended national average for CPI caseloads is 12 open cases at a time. Since the Grand Jury issued its recommendations in the Nubia Report, DCF has focused on trying to get its CPI caseloads lowered. Post-Barahona, average CPI caseloads have been reduced to 15-16 cases. Reducing, or maintaining reduced caseloads is an ever present challenge when one considers that some CPIs, on average, get assigned to investigate 15-20 new cases every month. As a result, some CPIs have active open investigations of up to 30 cases. This reality creates a huge incentive for CPIs to close cases prematurely or to find that the allegations of maltreatment were "unfounded". Therefore, it is essential that DCF do all it can to get manageable caseloads for its CPIs. It is apparent that the number of child maltreatment allegations and investigations is not going down.

The only effective way to reduce CPI caseloads is to hire more investigators to do the work. Of the 110 additional FTEs given by the legislature, the Miami Regional Office received authorization to hire twenty (20) new CPIs. However, reducing the caseload is not as simple as getting cases to the crop of new Investigators. Those investigators will have to be educated on the law, trained in their hybrid police/social worker role and given the duties and responsibilities that will come with that job. This takes time. We hope that in time DCF will achieve its goal of reducing CPI caseloads to ten (10) open cases.

IV. TECHNOLOGICAL ADVANCES

- *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.*

Funding recommendations in the Nubia report were made at a time when Florida was experiencing successive years of budget cuts and budget deficits. However, at the end of the 2011 legislative session, to its credit, the Florida Legislature provided special funding on several

occasions that permitted DCF to implement some major technological advances on the front end of the process.

Our predecessor Grand Jury cited several deficiencies in the processes and practices that were in place at that time. For instance, if several calls were made to the Hotline by different people even if over just a few days, one Hotline Counselor would not be aware that a prior abuse call had been made involving the same family or child. To make matters worse, if the allegations in one of those complaints were sufficient to trigger a referral to a CPI, absent a search of several different databases, the investigator would not be aware of the existence of the other calls or allegations. This was a serious failing and contributed to the tragedy in the Barahona case.

The 2011 special appropriation led to technological improvements that now allow Hotline Counselors to compile and run background checks on persons implicated in child maltreatment allegations. These checks include criminal history or other relevant information that may exist in databases for the NCIC, FCIC, Florida Department of Law Enforcement, Department of Motor Vehicles and others. With the assistance of the Command Center, much of this information can be sent to the Regional Offices with the original report.

Another technological improvement involves the way complaints can be made. Obviously, the primary method by which reports of child abuse are received at the call center is through use of the telephone. Now, with the availability of new software, persons who want to report child abuse can do so on-line through a website created for that purpose. The website format is designed so that the reporter is able to remain anonymous and/or leave contact information for follow-up by the Hotline Counselors. The availability of this new technology allows for a shorter wait time for those calling in and permits Hotline Counselors to spend more time with the callers to ensure they obtain all relevant information regarding the child abuse/neglect allegations.

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

As to 24-hour access to their case files, all CPIs have laptop computers that can be used where ever WiFi is available. In situations where WiFi is not available CPIs can establish a connection to the entire FSFN file via their mobile phone.

V. THE MIAMI HERALD'S *INNOCENTS LOST* SERIES

During our term, the Miami Herald ran its series entitled *Innocents Lost.* Although many of the items reported were not the focus of our investigation, we followed the series and were deeply troubled by at least three aspects of the Herald's detailed reports. The news articles highlighted the fact that there were obvious and repeated discrepancies between DCF and the Herald over the number of Florida's reported child deaths due to abuse or neglect. First, in all instances, the numbers given by the Herald, based on its review of DCF's own records, were higher. Reportedly, numbers tallied by an independent source were also higher than those reported by DCF.

Second, the definition for neglect, in connection with child deaths was changed. The new definition added an "intent" component to neglect. The effect of this change was that deaths previously counted would no longer be included since DCF deemed they did not occur because of neglect. As previously stated in this report, the top two causes of death for children 0-4 years of age were unsafe sleeping and drowning. Under the revised guidelines, DCF will only verify drowning and accidental suffocation deaths if a parent **deliberately** placed his or her child in danger. A few examples from the Miami Herald article underscore the impact of this change on actual cases.

> During Memorial Day weekend in 2011, the mother of a 1-year-old boy was texting at poolside during a holiday cookout at a community pool. Her toddler went under the surface and did not come up. DCF declined to verify the boy's death as stemming from neglect, reasoning that, because there were 20 other parents at the party, the behavior of his 24-year-old mother was no more neglectful than other parents visiting the public pool.
>
> One 2-year-old drowned in her uncle's pool in August 2011 when his mother was not paying attention. A half-year earlier, the mother had been the subject of a report that her drug use and improper supervision endangered the child. The death was not verified as neglect by DCF because "The death did not appear to occur as a result of a direct willful act of the caregiver." Instead, the drowning "was a result of [the mother] not providing essential supervision for her."
>
> On March 31, 2011, a mother went to bed with her 1-month old newborn beside her. The mother had signed a "Safe Sleep Notification Form" twice, affirming that she had been warned of the dangers of sleeping in the same bed as her newborn. The 23-year-old mother had an extensive history of drug abuse and was taking methadone every day to wean her off a years-long pain pill addiction. When the mother awoke, her infant was "unresponsive and turning purple in

color," a report said. The cause of the newborn's death was accidental asphyxia. The case was closed as unverified.

On Feb. 22, 2013, a 35-day-old boy was smothered after his parents placed him in an adult bed between them. The newborn's mother awoke to find him not breathing and "white in color." The official cause of death was accidental suffocation and strangulation. Both parents tested positive for drugs, which included marijuana. "Case is being closed with not substantiated findings of death, due to not being able to determine which caregiver was responsible for the rollover onto the child," a report said.[22]

To a person, each member of the Grand Jury who reviewed the brief summaries above concluded that each of these preventable child deaths occurred due to the neglect of each child's parent(s). We are at an utter loss to understand how those who labor in the field of child protection and child welfare could intentionally and deliberately find that these deaths were **not** verified as acts of neglect. If DCF's conclusions in this regard are based on "DCF's top death review coordinator" writing "new guidelines for investigating child deaths that redefine neglect", then those guidelines are worse than useless and should be changed. Further, we understand from the articles that in child death cases with similar factual situations DCF employees in one region were finding neglect while DCF employees in another region determined there was no neglect. Clearly, inconsistencies in the verification of drowning and accidental asphyxiation deaths related to neglect by the Department of Children and Families is a major problem. These deaths are actually preventable! The inconsistency in verifications directly affects the number of child deaths included in the Annual Child Abuse Death Review Report and skews the big picture of how many deaths in Florida are actually occurring due to neglect. To fix this and to create a truer picture of how many of these deaths are occurring due to neglect:

We recommend that DCF stop using the 2010 revised guidelines that redefined neglect.

We recommend that DCF revert to using the same neglect definition and guidelines that were in effect prior to the 2010 revisions.

To reduce the inconsistencies in the verification of drowning and accidental suffocation deaths that occur in the different DCF Regional Offices, we recommend that DCF create standards of interpretation that are applied uniformly throughout the state.

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[22]Innocents Lost, Florida's Undercount of Child Abuse Deaths.
http://www.miamiherald.com/projects/2014/innocents-lost/stories/undercount/

Once those standards are prepared, we recommend that DCF conduct trainings for all DCF staff who are involved with verifying causes of death to ensure that factually similar cases of neglect will be verified as neglect regardless of where they occur.

Finally, Florida's Child Abuse Death Review Committee ("CADRC") prepares and issues an Annual Report to the governor, President of the Senate and Speaker of the House. The information on Florida child deaths included in the Annual Child Abuse Death Review Report, for the most part, are obtained from DCF. The CADRC can only review verified child death cases and DCF staff are doing the verifications. According to one of the Miami Herald news articles, in the past, DCF released data to the CADRC that reported the total number of child deaths DCF determined were due to abuse or neglect. Years ago DCF also revealed how many of the child deaths occurred after DCF had prior familial contact. Apparently, DCF stopped providing the number of "deaths with priors" in the report.

The collective result of these observations are: 1) the public does not have confidence in the accuracy of the number of child deaths reported; 2) aside from being misleading, reported reductions in the total number of deaths may only be a consequence of changing the definitions of abuse and neglect; and 3) the failure to report "deaths with priors" takes away one barometer that we use to see how effective DCF is in fulfilling its mission of protecting Florida's abused, neglected and abandoned children. Nevertheless, we remain encouraged based on a news editorial[23] of bold action that is about to be taken by new interim DCF Secretary Mike Carroll, the former Sun Coast Regional Director for DCF. According to the editorial, the interim Secretary's plan is to develop a new website that will be accessible at myflfamilies.com.

> The site will detail every child death reported to the state's abuse hotline. Within 72 hours of a child's death, the public can view the deceased's name, age, date of death and, if it's been determined, the cause of death and a brief narrative of how the child died. After the cases are closed, a death report will be added. The site also will note whether the deceased's family was previously known to DCF. And users will be able to search by county, a tool Carroll anticipates will help DCF tailor education and safety campaigns. Carroll expects the website to debut in about two weeks and feature six years of data by September and 10 years' worth of information by the end of the year.[24]

[23] http://www.tampabay.com/opinion/editorials/editorial-progress-on-protecting-children/2184316
[24] Id.

We believe this openness will help restore the public's confidence in the numbers reported by DCF and give everyone the opportunity to monitor how well (or how poorly) DCF is preforming in this area. To assist in that effort:

> ***We recommend that in addition to DCF providing information about child deaths on the website (as proposed by the Interim Secretary), DCF should reinstate its practice of including "deaths with priors" in its reports.***

VI. CONCLUSION

Nubia Barahona's death was a major tragedy that brought immense attention to DCF, to its handling of Child Protective Investigations and to its relationship to Community Based Organizations and the Case Managers they use to provide services to children and families in need. Our predecessor Grand Jury discovered there were some major systemic problems with the way DCF processed and investigated reports of child maltreatment. The Grand Jury believed that implementation of the recommendations in the Nubia Report would fix many of those problems and reduce the number of child maltreatment deaths. We believe DCF and the Florida Legislature responded very well to many of the recommendations contained therein.

The technological advances, computer system and software upgrades, adoption of the Florida Safety Decision Making Methodology and creation of a career track for Child Protective Investigators should bode well for Florida's abused, neglected or abandoned children. However, we call on DCF and the legislature to make more changes and improvements. The legislature must make funding DCF a major priority. They must give money to hire additional investigators. This will reduce caseloads and give investigators more time to devote to these troubling cases. Further, DCF must do all it can to hire, train and retain quality employees. DCF must also continue to insert checks and balances in its child protective services investigation process (like pre-commencement conferences and Quality Assurance staff review on open cases). The Agency must be ever vigilant in seeking to find and adopt best practices for evaluating complaints, conducting investigations and assessing actions to be taken when children are found to be in unsafe situations. Further, accurate reporting of the success and failures, including child deaths, should restore public confidence in the agency and its reports. We believe implementation of these recommendations will assist in that effort and further reduce the number of preventable child deaths.

VII. RECOMMENDATIONS

2. *We recommend that all CPI applicants receive and pass a Behavioral Assessment Test as part of the application process.*
3. *We recommend that DCF conduct an evaluation of the pilot projects to determine whether there has been a decrease in the attrition if its CPIs and an increase in the quality of the investigations being conducted by CPIs utilizing the paired CPI model.*
4. *If successful, we recommend that the Legislature provide funding and sufficient FTEs to replicate this model for the rest of the State of Florida.*
5. *We recommend that the Florida Legislature, at a minimum, consider doubling the number of FTEs dedicated to enhancing the operation of the Quality Assurance Unit with review of open CPI investigations.*
6. *We recommend that DCF use the additional Quality Assurance Unit FTEs to deploy Quality Assurance personnel to those regions of the State that are not presently receiving such real-time review of open cases.*
7. *We recommend that DCF stop using the 2010 revised guidelines that redefined neglect.*
8. *We recommend that DCF revert to using the same neglect definition and guidelines that were in effect prior to the 2010 revisions.*
9. *To reduce the inconsistencies in the verification of drowning and accidental suffocation deaths that occur in the different DCF Regional Offices, we recommend that DCF create standards of interpretation that are applied uniformly throughout the state.*
10. *Once those standards are prepared, we recommend that DCF conduct trainings for all DCF staff who are involved with verifying causes of death to ensure that factually similar cases of neglect will be verified as neglect regardless of where they occur.*
11. *We recommend that in addition to DCF providing information about child deaths on the website (as proposed by the Interim Secretary), DCF should reinstate its practice of including "deaths with priors" in its reports.*

FLORIDA SAFETY DECISION MAKING METHODOLOGY
Child Present Danger Assessment

Case Name:
Worker Name:
Intake/Investigation ID:

FSFN Case ID:
Assessment Date:
Completed Date:

IDENTIFICATION OF THREATS OF DANGER TO A CHILD

I. DANGER THREATS

(Severity and significance of diminished Parent/Legal Guardian Protective Capacities as it relates to child vulnerability which creates a threat to child safety. The vulnerability of each child needs to be considered throughout information collection and assessment)

Yes	No	
☐	☐	1. Parent/Legal Guardian/Caregiver is not meeting child's basic and essential needs for food, clothing and/or supervision, AND child is/has already been seriously harmed or will likely be serious harmed.
☐	☐	2. Parent/Legal Guardian/Caregiver's intentional and willful act caused serious physical injury to the child, or the caregiver intended to seriously injury the child
☐	☐	3. Parent/Legal Guardian/Caregiver is violent, impulsive, or acting dangerously in ways that have seriously harmed the child or will likely seriously harm the child.
☐	☐	4. Parent/Legal Guardian/Caregiver is threatening to seriously harm the child; Parent/Legal Guardian is fearful he/she will seriously harm the child.
☐	☐	5. Parent/Legal Guardian/Caregiver views child and/or acts toward the child in extremely negative ways AND such behavior has or will result in serious harm to the child.
☐	☐	6. Child shows serious emotional symptoms requiring immediate intervention and/or lacks behavioral control and/or exhibits self-destructive behavior that Parent/Legal Guardian/Caregiver is unwilling or unable to manage.
☐	☐	7. Child has a serious illness or injury (indicative of child abuse) that is unexplained, or the Parent/Legal Guardian/Caregiver explanations are inconsistent with the illness or injury.
☐	☐	8. The child's physical living conditions are hazardous and a child has already been seriously injured or will likely be seriously injured. The living conditions seriously endanger a child's physical health.
☐	☐	9. There are reports of serious harm and the child's whereabouts cannot be ascertained and/or there is a reason to believe that the family is about to flee to avoid agency intervention and/or refuses access to the child and the reported concern is significant and indicates serious harm.
☐	☐	10. Parent/Legal Guardian/Caregiver is not meeting the child's essential medical needs AND the child is/has already been seriously harmed or will likely be seriously harmed.
☐	☐	11. Other. Explain:

Exhibit A

FLORIDA SAFETY DECISION MAKING METHODOLOGY
Child Present Danger Assessment

II. SAFETY INTERVENTION

☐ No Present Danger Threats are identified.

☐ Danger Threat(s) identified - Present danger threat is identified. Proceed to develop or modify existing Safety Plan, continue information collection and Family Functioning Assessment.

Briefly describe assessment of the Parent/Legal Guardian/Caregiver's historical and current capacity to, ability to, and willingness to protect the child.

If at any time during agency intervention a danger threat is determined, immediately proceed to implementing a Safety Plan and conducting an In-Home Safety Analysis.

FLORIDA SAFETY DECISION MAKING METHODOLOGY
Information Collection and Family Functioning Assessment

Case Name: **Initial Intake Received Date:**

Worker Name: **Date Completed:**

FSFN Case ID: **Intake/Investigation ID:**

I. MALTREATMENT AND NATURE OF MALTREATMENT

What is the extent of the maltreatment? What surrounding circumstances accompany the alleged maltreatment?

Related Impending Danger Threats **Based on case information specific to the Extent of Maltreatment and Circumstances Surrounding Maltreatment Assessment domains, indicate Yes, Impending Danger exists or No, Impending Danger does not exist.**	Impending Danger Threat? Yes	No
Parent's/Legal Guardian's or Caregiver's intentional and willful act caused serious physical injury to the child, or the parent/legal guardian or caregiver intended to seriously injure the child.	☐	☐
Child has a serious illness or injury (indicative of child abuse) that is unexplained, or the Parent's/Legal Guardian's or Caregiver's explanations are inconsistent with the illness or injury.	☐	☐
The child's physical living conditions are hazardous and a child has already been seriously injured or will likely be seriously injured. The living conditions seriously endanger the child's physical health.	☐	☐
There are reports of serious harm and the child's whereabouts cannot be determined and/or there is a reason to believe that the family is about to flee to avoid agency intervention and/or the family refuses access to the child to assess for serious harm.	☐	☐
Parent/Legal Guardian or Caregiver is not meeting the child's essential medical needs AND the child is has already been seriously harmed or will likely be serious harmed.	☐	☐
Other. Explain:	☐	☐

II. CHILD FUNCTIONING

How does the child function on a daily basis? Include physical health, development; emotion and temperament; intellectual functioning; behavior; ability to communicate; self-control; educational performance; peer relations; behaviors that seem to provoke parent/caregiver reaction/behavior; activities with family and others. Include a description of each child's vulnerability based on threats identified.

Related Child Functioning Impending Danger Threats: **Based on case information specific to the Child Functioning Assessment domain, indicate Yes, Impending Danger exists or No, Impending Danger does not exist.**	Impending Danger Threat? Yes	No
Child shows serious emotional symptoms requiring intervention and/or lacks behavioral control and/or exhibits self-destructive behavior that the Parent/Legal Guardian or Caregiver are unwilling or unable to manage to keep the child safe	☐	☐

III. ADULT FUNCTIONING

How does the adult function on a daily basis? Overall life management. Include assessment and analysis of prior child abuse/neglect history, criminal behavior, impulse control, substance use/abuse, violence and domestic violence, mental health; include an assessment of the adult's

Exhibit B

physical health, emotion and temperament, cognitive ability; intellectual functioning; behavior; ability to communicate; self-control; education; peer and family relations, employment, etc.

Related Adult Functioning Impending Danger Threats: **Based on case information specific to the Adult Functioning Assessment domain, indicate Yes, Impending Danger exists or No, Impending Danger does not exist.**	Impending Danger Threat? Yes	No
Parent/Legal Guardian or Caregiver is violent, impulsive, cannot or will not control behavior or is acting dangerously in ways that have seriously harmed the child or will likely seriously harm to the child.	☐	☐

IV. PARENTING

General – What are the overall, typical, parenting practices used by the parents/legal guardians? Discipline/Behavior Management – What are the disciplinary approaches used by the parents/legal guardians, and under what circumstances?

Related Parenting Impending Danger Threats: **Based on case information specific to the Parenting General and Parent Discipline Assessment domains, indicate Yes, Impending Danger exists or No, Impending Danger does not exist.**	Impending Danger Threat? Yes	No
Parent/Legal Guardian or Caregiver is not meeting child's basic and essential needs for food, clothing, and/or supervision AND the child is/has already been seriously harmed or will likely be seriously harmed.	☐	☐
Parent/Legal Guardian or Caregiver is threatening to seriously harm the child and/or parent/legal guardian or caregiver is fearful he/she will seriously harm the child.	☐	☐
Parent/Legal Guardian or Caregiver views child and/or acts toward the child in extremely negative ways AND such behavior has or will result in serious harm to the child.	☐	☐

V. PARENT/LEGAL GUARDIAN PROTECTIVE CAPACITIES ANALYSIS

If there are more than five Parent/Legal Guardians to assess, complete Appendix A – Parent/Legal Guardian Protective Capacities Analysis

Adults	Capacity Categories and Types																	
	Behavioral					Cognitive						Emotional						
	Controls Impulses	Takes Action	Sets aside own needs for child	Demonstrates adequate skills	Adaptive as a Parent/Legal Guardian	Is self aware	Is intellectually able	Recognizes threats	Recognizes child's needs	Understands protective role	Plans and articulates plans for protection	Meets own emotional needs	Is resilient	Is tolerant	Is stable	Expresses love, empathy, sensitivity to the child	Is positively attached with child	Is aligned and supports the child
	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Parent/Legal Guardian Protective Capacity Determination Summary:	Yes	No
Protective capacities are sufficient to manage identified threats of danger in relation to child's vulnerability?	☐	☐

VI. CHILD SAFETY DETERMINATION AND SUMMARY

If there are more than five children to assess, complete Appendix B – Child Safety Determination and Summary

Child	Safety Determination
	☐ Safe – No impending danger safety threats that meet the safety threshold. ☐ Safe – Impending danger threats are being effectively controlled and managed by a parent/legal guardian in the home. ☐ Unsafe
	☐ Safe – No impending danger safety threats that meet the safety threshold. ☐ Safe – Impending danger threats are being effectively controlled and managed by a parent/legal guardian in the home. ☐ Unsafe
	☐ Safe – No impending danger safety threats that meet the safety threshold. ☐ Safe – Impending danger threats are being effectively controlled and managed by a parent/legal guardian in the home. ☐ Unsafe
	☐ Safe – No impending danger safety threats that meet the safety threshold. ☐ Safe – Impending danger threats are being effectively controlled and managed by a parent/legal guardian in the home. ☐ Unsafe
	☐ Safe – No impending danger safety threats that meet the safety threshold. ☐ Safe – Impending danger threats are being effectively controlled and managed by a parent/legal guardian in the home. ☐ Unsafe

Child Safety Analysis Summary:

VII. IN-HOME SAFETY ANALYSIS AND PLANNING

	Yes	No
The Parent/Legal Guardians are willing for an in-home safety plan to be developed and implemented and have demonstrated that they will cooperate with all identified safety service providers.	☐	☐
The home environment is calm and consistent enough for an in-home safety plan to be implemented and for safety service providers to be in the home safely.	☐	☐
Safety services are available at a sufficient level and to the degree necessary in order to manage the way in which impending danger is manifested in the home.	☐	☐

An in-home safety plan and the use of in-home safety services can sufficiently manage impending danger without the results of scheduled professional evaluations.	☐	☐
The Parent/Legal Guardians have a physical location in which to implement an in-home safety plan.	☐	☐

If "Yes" to all of SECTION VII. above – Child(ren) will remain in the home with an In-Home Safety Plan

☐ **In-Home Safety Plan**

The child(ren) is/are determined "unsafe," but through in-home safety analysis above, an in-home Impending Danger Safety Plan is executed which allows a child to remain in the home with the use of in-home safety management and services in order to manage the way in which impending danger is manifested in the home while treatment and safety management services can be determined and initiated.

- ❖ A safety plan must be implemented, monitored, and actively managed by the Agency.
- ❖ The case will be opened for safety management and case management services

If "No" to any of SECTION VII. above – Out of Home Safety Plan is the only protective intervention possible for one or more children. Out of Home Safety options should be evaluated from least intrusive (e.g. family-designated arrangements as a task or condition of the Out of Home Safety Plan) to most intrusive (e.g. agency removal and placement).

Given family dynamics and circumstances, also evaluate and determine if In-Home Safety Plan needs judicial oversight to facilitate court accountability. Refer to administrative code and operating manual for guidance.

☐ **Out-of-Home Safety Plan**

- ❖ An impending danger safety plan must be implemented, monitored, and actively managed by the Agency.
- ❖ The case will be open for safety management, case management, and reunification services

If an Out-of-home Safety Plan is necessary, summarize reason for out of home safety actions and conditions for return. Conditions for return should be related to reasons for removal and behaviorally based. These are parent/legal guardian actions and behaviors that must be demonstrated to sufficiently address the impending danger and allow for the child to safely return home with an In Home Safety Plan and continued safety and case plan services and management.

FLORIDA SAFETY DECISION MAKING METHODOLOGY
Family (Household) Risk Assessment of Child Abuse/Neglect

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Case Name: _____ **FSFN Case ID:** _____

Investigation ID: _____ **Assessment Date:** ____/____/____

Participant Name	Date of Birth	Role

NEGLECT **Score**

N1. Current complaint is for neglect
- o No 0
- o Yes ..... 1 _____

N2. Prior investigations (*assign highest score that applies*)
- o None 0
- o One or more, abuse only 1
- o One or two for neglect 2
- o Three or more for neglect ..... 3 _____

N3. Household has previously received ongoing child protective services
- o No 0
- o Yes ..... 1 _____

N4. Number of children involved in the child abuse/neglect incident
- o One, two, or three 0
- o Four or more ..... 1 _____

N5. Age of youngest child in the home
- o 2 or older 0
- o Under 2 ..... 1 _____

N6. Primary caregiver provides physical care consistent with child needs
- o Yes 0
- o No ..... 1 _____

N7. Primary caregiver has a historic or current mental health problem
- o No. 0
- o Yes ..... 1 _____

N8. Primary caregiver has historic or current alcohol or drug problem
- o Not Applicable 0
- o One or more apply (*mark applicable items and add for score*):
  - ☐ Alcohol (current or historic) 1
    - ☐ Current (within the last 12 months)
    - ☐ Historic (prior to last 12 months)
  - ☐ Drug (current or historic) ..... 1 _____
    - ☐ Current (within the last 12 months)
    - ☐ Historic (prior to last 12 months)

N9. Characteristics of children in household
- o Not Applicable 0
- o One or more present (*mark applicable items and add for score*):
  - ☐ Medically fragile or failure to thrive 1
  - ☐ Developmental, physical, or learning disability . 1
  - ☐ Positive toxicology screen at birth ..... 1 _____

N10. Housing
- o Not Applicable 0
- o One or more apply (*mark applicable items and add for score*):
  - ☐ Current housing is physically unsafe 1
  - ☐ Homeless ..... 2 _____

TOTAL NEGLECT RISK SCORE _____

ABUSE **Score**

A1. Current complaint is for abuse
- o No 0
- o Yes ..... 1 _____

A2. Number of prior abuse investigations
- o None 0
- o One 1
- o Two or more ..... 2 _____
- (actual number: _____)

A3. Household has previously received ongoing child protective services
- o No 0
- o Yes ..... 1 _____

A4. Prior injury to a child resulting from child abuse/neglect
- o No. 0
- o Yes ..... 1 _____

A5. Primary caregiver's assessment of incident
- o Not Applicable 0
- o One or more apply (*mark applicable items and add for score*):
  - ☐ Blames child for maltreatment 1
  - ☐ Justifies maltreatment ..... 2 _____

A6. Domestic violence in the household in the past year
- o No. 0
- o Yes ..... 2 _____

A7. Primary caregiver characteristics
- o Not Applicable 0
- o One or more apply (*mark applicable items and add for score*):
  - ☐ Provides insufficient emotional/psychological support 1
  - ☐ Employs excessive/inappropriate discipline 1
  - ☐ Domineering ..... 1 _____

A8. Primary caregiver has a history of abuse or neglect as a child
- o No. 0
- o Yes ..... 1 _____

A9. Secondary caregiver has historic or current alcohol or drug problem
- o No 0
- o Yes, one or more apply ..... 1 _____
  - ☐ Alcohol
    - ☐ Current (within the last 12 months)
    - ☐ Historic (prior to last 12 months)
  - ☐ Drug
    - ☐ Current (within the last 12 months)
    - ☐ Historic (prior to last 12 months)

A10. Characteristics of children in household
- o Not Applicable 0
- o One or more apply (*mark applicable items and add for score*):
  - ☐ Delinquency 1
  - ☐ Developmental or learning disability 1
  - ☐ Mental health or behavioral problem ..... 1 _____

TOTAL ABUSE RISK SCORE _____

Exhibit C

FLORIDA SAFETY DECISION MAKING METHODOLOGY
Family (Household) Risk Assessment of Child Abuse/Neglect

SCORED RISK LEVEL. Assign the family's scored risk level based on the highest score on either the neglect or abuse index, using the following chart.

Neglect Score	Abuse Score	Scored Risk Level
o 0–1	o 0–1	o Low
o 2–4	o 2–4	o Moderate
o 5–8	o 5–7	o High
o 9 +	o 8 +	o Very High

POLICY OVERRIDES. Mark yes if a condition shown below is applicable in this case. If any condition is applicable, override final risk level to very high.

o Yes o No 1. Sexual abuse case AND the perpetrator is likely to have access to the child.

o Yes o No 2. Non-accidental injury to a child younger than 2 years old.

o Yes o No 3. Severe non-accidental injury.

o Yes o No 4. Caregiver(s) action or inaction resulted in death of a child due to abuse or neglect (previous or current).

DISCRETIONARY OVERRIDE. If a discretionary override is made, mark yes, mark override risk level, and indicate reason. Risk level may be overridden one level higher.

o Yes o No 5. If yes, override risk level (mark one): o Moderate o High o Very High

Discretionary Override Reason:

FINAL RISK LEVEL (mark final level assigned): o Low o Moderate o High o Very High

NAME OF DEFENDANT	CHARGE	INDICTMENT RETURNED	DATE
EMIN JOEL ROSALES RAMIREZ, Also known as "FLACO"	First Degree Murder Murder/Premeditated/Attempt Deadly Weapon or Aggravated Battery	True Bill	11/19/13
DEREK VERNON MEDINA	First Degree Murder Shooting or Throwing Deadly Missile Child Neglect/No Great Bodily Harm	True Bill	11/26/13
(A) CLIFTON DICKSON, also known as "BIG MAN", and (B) JULIO MONTEZ MORRIS, also known As "BOO", also known as "BOO BA"	First Degree Murder Murder/Premeditated/Attempt/Deadly Weapon or Aggravated Battery	True Bill	11/26/13
ANTHAWN D. RAGAN, JR.	First Degree Murder Murder/Premeditated/Attempt/Deadly Weapon or Aggravated Battery Attempted Felony Murder with a Deadly Weapon or Aggravated Battery Robbery Using Deadly Weapon or Firearm Robbery Using Deadly Weapon or Firearm Robbery Using Deadly Weapon or Firearm Robbery Using Deadly Weapon or Firearm Robbery Using Deadly Weapon or Firearm Aggravated Battery/Deadly Weapon Aggravated Assault With a Firearm Aggravated Assault With a Firearm Aggravated Assault With a Firearm Aggravated Assault With a Firearm Aggravated Assault With a Firearm	True Bill	12/10/13
WILMEN DIAZ	First Degree Murder Murder/Premeditated/Attempt/Deadly Weapon or Aggravated Battery	True Bill	12/10/13

NAME OF DEFENDANT	CHARGE	INDICTMENT RETURNED	DATE
RONALD DEVIN WASHINGTON	First Degree Murder Murder/Premeditated/Attempt/Deadly Weapon or Aggravated Battery Battery Battery Stalking/Aggravated/Court Order/Prior Injunction Restraint Stalking/Aggravated Violation of Condition of Pretrial Release/Domestic Violence Violation of Condition of Pretrial Release/Domestic Violence Battery	True Bill	01/15/14
RICARDO ROBINSON	First Degree Murder	True Bill	01/22/14
ANTHAWN D. RAGAN, JR. (A) and TERRY A. NEALY (B)	First Degree Murder	True Bill	01/22/14
CEDRIC JACKSON	First Degree Murder Robbery Using Deadly Weapon or Firearm	True Bill	02/05/14
CLAUDE ALEXIS	First Degree Murder Child Abuse/Aggravated/Great Bodily Harm/Agg Batt/Firearm	True Bill	02/12/14
KENDRICK A. DAVIS	First Degree Murder Robbery Using Deadly Weapon or Firearm Grand Theft 3rd Degree	True Bill	02/12/14
ANTWAN LEMOAD SMITH, also known as "CUT THROAT"	First Degree Murder Attempted Armed Robbery	True Bill	02/26/14
QUINTON NELSON, also known as CHUCK	First Degree Murder Robbery/Deadly Weapon/Firearm/ Attempt	True Bill	03/19/14

NAME OF DEFENDANT	CHARGE	INDICTMENT RETURNED	DATE
ALFONSO LOPEZ DE QUERALTA	First Degree Murder Burglary with Assault or Battery Therein / While Armed Violation of Injunction Against Domestic Violence Possession Firearm Ammunition/ Domestic Violence Injunction	True Bill	03/19/14
"A" DEDRICK BROWN and "B" WILLIE BARNEY	First Degree Murder Murder/Premeditated/Attempt Deadly Weapon or Aggravated Battery Robbery Using Deadly Weapon or Firearm	True Bill	03/19/14
NELSON SANTONI	First Degree Murder Burglary With Assault or Battery Therein / While Armed Robbery/Carjacking/Armed Grand Theft/3rd Degree/Armed	True Bill	03/26/14
JAMERE JAMES HANNA	First Degree Murder Robbery Using Deadly Weapon or Firearm Robbery using Deadly Weapon or Firearm	True Bill	04/09/14
JESUS MAQUEIRA	First Degree Murder Aggravated Stalking/Firearm/Deadly Weapon/Prior Restraint/Injunction	True Bill	04/23/14
JUAN CARLOS FERNANDEZ	First Degree Murder First Degree Murder Burglary With Assault or Battery Therein/While Armed	True Bill	04/30/14

ACKNOWLEDGMENTS

The Grand Jury would like to express our sincere gratitude to Rose Anne Dare, Administrative Assistant and Nelido Gil, Bailiff, for their dedication and commitment with assisting this jury in fulfilling its duties.

We would especially like to thank State Attorney Katherine Fernandez Rundle, Assistant State Attorney Susan Leah Dechovitz, and Chief Assistant State Attorney Don L. Horn for their dedication, professionalism and skill in presenting the facts and explaining the law, which made our tasks more enjoyable and certainly easier to perform.

On a personal note, I wish to thank my fellow Grand Jurors for the dedication to duty they demonstrated during the past six months. For the members of the Grand Jury it has been a privilege to be able to participate in this process.

Respectfully submitted,

William Hernandez, Foreperson
Miami-Dade County Grand Jury
Fall Term, 2013

ATTEST:

Sarabeth Beitchman
Clerk

Date: June 24, 2014