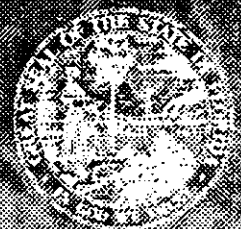


"AN ACTIVE, ALERT CHILD WHO WAS FULL OF LIFE."

Born  
Dec. 21, 1987  
Died  
May 13, 1995

# GOVERNOR'S PANEL ON CHILD PROTECTION ISSUES

A Review of the Lucas Ciambrone Case





# GOVERNOR'S PANEL ON CHILD PROTECTION ISSUES

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# Preamble

**G**overnment can have no higher calling or obligation than to protect the lives of its most vulnerable citizens. Communities can no better express their humanity than to actively and personally engage their neighbors in the individual and collective support of a quality of life that reflects at least a minimum standard of health, safety and decency. Unfortunately, for Lucas Ciambrone neither his government nor his community met this test. He has paid for their failures with his life. The frequency with which panels such as this are convened in Florida and elsewhere across the nation is a damning indictment of our unwillingness or inability as a nation, state or community to protect and nurture all our children at even the most basic level. Even more damning are the number of child deaths that do not even merit the appointment of a committee or the conduct of a public review as to the cause of and responsibility for their tragic human capital. A community that ignores its children ignores its future. Florida, all of Florida, must make children its first priority, if not for the moral and ethical responsibilities of the present, then the enlightened self-interest for the future.

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*Florida, must make  
children its first priority,*

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On July 26, 1995, Governor Lawton Chiles appointed this 10-member community review panel to conduct an independent inquiry into the death of 7-year-old Lucas Ciambrone, a former Manatee County foster child whose adoptive parents were charged with his murder. The community review panel, with representation from local child advocates and professionals in health care, law enforcement, social services and education were charged with reviewing the Ciambrone case and recommending improvements to the child protection system.

The panel has found evidence of legislative indifference, organizational ineptitude, inadequate resources, human error and poor judgment. At the same time, the panel has also found instances of an organization struggling to improve itself and the quality of care it provides to families and children in spite of embarrassingly deficient resources. The panel identified individuals whose commitment is unquestionable and whose efforts approached the heroic. But for

Lucas Ciambrone, Bradley McGee and Cory Greer and countless others before them, their verdicts lack any such ambiguity. The panel must sadly and reluctantly conclude that Florida has not yet made the health and safety of its children its highest priority - children are not first in Florida! Likewise, the

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*But for Lucas Ciambrone, Bradley McGee and Cory Greer and countless others before them, their verdicts lack any such ambiguity.*

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serious organizational and systemic deficiencies in the child protection system, if left to fester uncorrected, or only cosmetically corrected, can only assure a repetition of the sad duties of this panel. Child Welfare is at the precarious point where fallible, human judgment confronts the human condition at its worst.

This report is organized into several sections. The first section consists of the panel's charges and is followed by the panel's findings, priority and additional recommendations and a conclusion. After nearly six months of review and deliberation the panel hopes that the full moral, executive and political authority of the Governor's office can be directed to implementing its recommendations. Unfortunately this is not the first such panel to be constituted and regrettably will likely not be the last. It is true that each journey starts with a single step. It is equally true that each journey ends with a final step. If that final step is never taken, the ghost of Lucas Ciambrone will inevitably be replaced by a new as yet unnamed, but equally tragic figure whose already small stature will be further dwarfed by the enormity of our individual and collective indifference.

# **Governor's Charges to the Panel**

*The district process for documenting, responding to and resolving complaints from families involved in the child protection system, including biological, foster and adoptive parents.*

*The method by which abuse and neglect calls are documented and shared by the Hotline staff and local caseworkers.*

*Policies, procedures and laws that may inhibit the department from responding to evidence of abuse or neglect in its early stages.*

*The separation of various parts of the child protection system—protective investigation, protective supervision, foster care, licensure, and adoption—and its effect on accountability and continuity of care.*

*Communication and relationships between child protection staff and foster care and adoptive parents.*

*The role of the community in the protection and care of children and families.*

*The process by which adoptive homes are screened and selected.*

*Immediate changes that need to be made to ensure a more pro-active community partnership to protect children.*

# Findings

## Child Protection System

1. HRS' Children and Families program continues to be funded inadequately for the demands and performance expectations placed upon it.
2. Repeated studies have shown staff turnover at HRS, especially in foster care, is too high, resulting in a lack of continuity and accountability. The current personnel structure is a disincentive to the provision of quality care, for a variety of reasons:
  - a) The system lacks a meaningful career ladder which would reward good performance;
  - b) The hierarchy of job classifications promotes turnover in foster care.
  - c) Salaries are too low to attract and retain qualified child protection workers;
  - d) Caseloads are unmanageable.
3. Entry level personnel often lack appropriate professional education and training related to child protection.
4. Issues relating to inadequate supervision which need to be addressed include:
  - a) A lack of qualified supervisors;
  - b) Inadequate training of entry level supervisors;
  - c) Unmanageable supervisor workloads;
  - d) Inadequate ongoing training and oversight of supervisors.

5. In the Lucas Ciambone case there was a lack of awareness and sensitivity to apparent conflicts of interest in some case planning activities. For example, Lucas was being seen by a therapist whose wife was his foster care counselor for a brief period of time.
6. In the Lucas Ciambone case internal quality assurance systems and accountability procedures failed to prevent and/or identify problems in the case.
7. In the Lucas Ciambone case there were numerous breakdowns in communication among staff, between organizational units and with outside agencies that masked the seriousness of the issues and problems in the case. The nature of the breakdowns, however, do not appear to be unique to this case.
8. Valuable staff time is lost due to poor scheduling of court appearances.
9. There is inadequate use of available technology in record keeping and information sharing within HRS' Children and Family program and among the various other state and local agencies involved in child protection.
10. Some medical providers report that foster children are being brought for medical care without medical records.

# **Foster Care**

1. The number and type of foster homes is inadequate. There is a particular shortage of homes that can care for children with emotional and behavioral problems. There are also inadequate professional supports for foster parents who have children with these problems.
2. Becoming a foster parent as a pathway to become an adoptive parent is increasingly common, however, the selection processes are different.
3. There are problems with recruitment and retention of quality foster homes. Shortages of foster parents leads to overcrowding in the available homes.
4. Placement pressures seem to lead to licensure of marginal homes. Currently, there is a prevailing attitude that it is a right to be a foster parent.
5. There are not enough safeguards or separation of responsibility in the licensing, re-licensing and placement processes.
6. HRS does not always follow its own recommended limits on the numbers and types of children to be placed in specific homes.
7. There is an absence of adequate services to maintain children with their families when it is in their best interest.
8. Ongoing training for foster parents is inadequate.
9. The satisfaction of foster parents with HRS is varied.

10. There is a shortage of emergency services for children who cannot be placed in foster care. The subsequent overuse of foster care homes as shelter care homes is sometimes inconsistent with the overall needs of the child placed in the foster home and those children already living in the foster home.
11. The current process of doing fingerprint checks for prospective foster parents is costly and time consuming.
12. Foster care services are not adequately integrated with other service systems throughout the state.
13. There is an absence of individualized case planning that is genuinely based on the needs and capabilities of each child and family.
14. Some foster parents reported not receiving medical and behavioral background information in a timely manner.

# **Adoptions Process**

1. Adoption maintenance subsidies are provided by HRS to adoptive parents of high risk children without periodic oversight which could identify unmet needs of both the adopted child and the adoptive parents.
2. Post-finalization, as well as pre-finalization services and supports to adoptive parents should be enhanced.
3. At the time of Lucas Ciambrone's adoption, adoptive home studies were not routinely done for foster parents in Manatee County.
4. The court's authorization of Lucas Ciambrone's adoption was flawed by reliance on incomplete documentation regarding proper consent to adoption and home studies.
5. The reservations of counselors regarding Lucas Ciambrone's adoption were not reviewed or considered at the HRS program office level.
6. At the time of Lucas Ciambrone's adoption there existed no active program of adoptive parent recruitment in Manatee County.

## **Abuse Hotline**

1. Confusion persists about where and when to report concerns regarding a child's well-being in a foster home - to local staff, central Hotline, law enforcement, etc.
2. There is no formal mechanism for feedback from reporters regarding their experiences with the Hotline.
3. At the time of Lucas Ciambrone's death, complaints regarding foster homes which were not accepted by the Hotline were not forwarded to district staff.
4. Questions persist regarding the interpretation of the criteria used by the Hotline staff regarding the acceptance of a report.
5. No Hotline or other HRS records exist to substantiate or refute claims that reports were made by citizens to the Hotline regarding abuse of Lucas Ciambrone.

# **Community Role**

1. Manatee County lacks a central information and referral system for children and families in need.
2. In the Lucas Ciambrone case the Guardian Ad Litem program failed to protect the child's interests. This was due, in part, to lack of meaningful oversight by the court.
3. The Guardian Ad Litem program is a good concept, but it lacks accountability. The existence of the program without accountability can give a false sense of security that a child's interests are being protected.
4. In the Lucas Ciambrone case there were instances when citizens failed to report suspected abuse of Lucas Ciambrone.
5. The current mechanism for monitoring home education (home schooling) programs is inadequate.
6. In the Lucas Ciambrone case the physicians and mental health professionals failed to provide continuity of care and regular reports to HRS on the condition of Lucas. The quality of medical and psychological care was also suspect in some instances.
7. In the Lucas Ciambrone case the lack of connection and trust between the local community and HRS was not sufficiently strong to generate an adequate sense of community responsibility for Lucas' welfare. The broader community showed little sense of ownership or responsibility in this situation.

Many local community officials and citizens were invited to testify before the panel but declined to participate.

8. In the Lucas Ciambrone case outside agencies were not adequately included in the case planning process.
9. Children's services are not adequately integrated throughout the state. This includes Alcohol, Drug Abuse and Mental Health, Juvenile Justice, Domestic Violence, Health, Developmental Services, Education, Children's Medical Services, Child Support Enforcement, etc.. Real and perceived issues of confidentiality can act as barriers to communication and integration of services.
10. An opportunity to assist Lucas' biological mother with domestic violence went unaddressed. Domestic violence resulted in the removal of Lucas and his siblings from their biological mother who, during their time in shelter, was killed in a domestic violence episode without the benefit of intervention.

# Recommendations

## **Priority Recommendation #1:**

HRS is required by statute to provide services to all abused and neglected children. HRS must be funded at a sufficient level to meet the service needs of these children. The total cost of serving an abused/neglected child in the state of Florida should be used by the Child Welfare Estimating Conference to determine minimum funding needs for children who require these services (e.g., \$25,000 per child in Hawaii). Limits must be placed on the number of children served unless funding follows duties and responsibilities for the protection of children.

## **Priority Recommendation #2:**

High turnover of staff continues to be a serious problem in terms of continuity and quality of care. The Governor and the Legislature must support HRS in its current plan to complete and implement the following:

- a. competency-based training for all child protection staff;
- b. revised job descriptions that incorporate the competencies identified as necessary to perform well;
- c. increased salaries and a career ladder within the discipline that will attract and retain professionals who, through education and experience, demonstrate the ability to make sound clinical decisions;
- d. mentorship of each new caseworker by an experienced caseworker so that sufficient guidance and support is available to new employees;
- e. a reduced caseload for a sufficient period of time that allows new caseworkers to learn and practice the responsibilities of their position;
- f. a manageable caseload for all child protection workers; and
- g. HRS should develop salary and educational incentives to attract and retain qualified BSW and MSW staff to its workforce. The professional development centres and the schools of social work should collaborate

to provide relevant social work knowledge and skills in HRS training programs. Schools of social work should ensure that HRS related issues and information are integrated in both the BSW and MSW curriculums. Twenty-five percent of students entering field placements from the state schools of social work should serve in HRS child protection internships.

### **Priority Recommendation #3:**

In the Lucas Ciambrone case there appeared to be adequate review procedures in place; however, they were not consistently followed. In each HRS district, a comprehensive and systematic quality improvement process should be in place that promotes a higher quality of care and service ethic within the department. This process must ensure that rules, policies and procedures are being followed and assess the quality of interventions. HRS should review the quality assurance model currently used in the Office of Public Health with a view to its adoption by social services.

### **Priority Recommendation #4:**

HRS must strictly adhere to a limit of no more than five children living in each foster home. A waiver of this limit should be done on an extremely limited basis, and only in cases of siblings. HRS must assure that its quality assurance mechanism includes careful monitoring of this issue.

### **Priority Recommendation #5:**

Each HRS district and sub-district should maintain an active outreach to the community to develop collaborative efforts to protect and care for children and families. These should build on existing efforts, including the restructuring of protective services in some counties (e.g., Duval County) to emphasize greater use of local resources to aid families, citizen review boards, citizen participation in recruitment campaigns for foster and adoptive parents, involvement of churches in recruitment of adoptive parents, and use of the media and the business community in recruitment campaigns.

# **Additional Recommendations**

## **Recommendation #6:**

There should be a formal mechanism in place to solicit feedback from reporters who use the Abuse Hotline. HRS should consider a mail survey mechanism as well as routine quality assurance audits that review screening criteria being used and decisions being made by Abuse Hotline staff.

## **Recommendation #7:**

All complaints to the Abuse Hotline regarding foster care, whether or not accepted, should be referred to the appropriate HRS district office for review, investigation and follow-up (as per Governor's direction in September 1995).

## **Recommendation #8:**

The legal requirement that complaints of child abuse/neglect of any child with an open HRS case must be made to the central Abuse Hotline, regardless of others who have been notified of the concern, should be enforced.

## **Recommendation #9:**

HRS should maintain records to substantiate or refute all complaints about foster parents made by citizens to the Abuse Hotline or local HRS office. (In September 1995, HRS enacted an internal mechanism to ensure such documentation.)

### **Recommendation #10:**

Current methods of screening, selecting, retaining and training foster parents and adoptive parents are inadequate. Foster parenting and adoption is a privilege, not a right. Meaningful foster and adoptive parent criteria and selection procedures must be put in place to ensure that foster and adoptive parents are adequately skilled and psychologically prepared to tend to the special needs of children. HRS must clearly articulate (by administrative rule) these criteria and the procedures for selection so that the selection process is a meaningful one and the department can defend its selection and denial of parents.

### **Recommendation #11:**

The department must develop a system of emergency and crisis services, which may include shelter care, with an emphasis on maintaining current placement, to end the problem of emergency placements overcrowding foster family homes.

### **Recommendation #12:**

HRS should test alternative methods for assigning caseworkers. Consistency and accountability may be better achieved by assigning the caseworker to the foster home rather than to the individual child in non-shelter care situations. The feasibility of clustering foster homes into neighborhood support groups should be tested (i.e., Hull House model).

### **Recommendation #13:**

Effective prevention models exist in some communities in the state of Florida which are significantly reducing the incidence of abuse and neglect, and therefore the need for child protective services (e.g., Healthy Families Pinellas). These programs should be expanded state-wide immediately.

### **Recommendation #14:**

The state of Florida must continue efforts to prevent foster care placements of abused and neglected children through such programs as Family Builders and Intensive Crisis Counseling Program.

### **Recommendation #15:**

The state of Florida must expand efforts to reunify children with their families through expansion of successful programs such as Homeward Bound, Fostering Individualized Assistance Program, etc.

### **Recommendation #16:**

The Secretary for HRS and the Commissioner of FDLE should share information and ascertain how HRS can receive fingerprint checks in a more timely and less costly fashion.

### **Recommendation #17:**

HRS must put a priority on preserving foster care placements that are adequate in meeting the needs of children. The system must provide sufficient economic and service supports to achieve this objective.

### **Recommendation #18:**

In an effort to increase staff productivity, HRS should examine hiring more direct services aides and using volunteers to perform time consuming tasks (e.g., transporting children, routine clerical tasks, etc.) currently given to the child protection staff whose expertise and skills are needed for reunification efforts, case planning and coordination.

### **Recommendation #19:**

The functions of licensing of foster parents and placing foster children must be carefully differentiated. These functions should be conducted by separate units to reduce the likelihood of a conflict of interests.

### **Recommendation #20:**

Health and human service boards should assume a leadership role in identifying and encouraging cooperative efforts between HRS and other community resources.

### **Recommendation #21:**

HRS should review the current advances in technology to assist caseworkers in record keeping and communication (e.g., laptops, networks, E-mail, etc.).

### **Recommendation #22:**

Certification procedures should be established for the following classes of child welfare workers: protective investigators, protective services workers, foster care counselors and adoption workers.

### **Recommendation #23:**

There should be significant integration of therapeutic foster care services within the existing foster care system in order to better serve children with emotional disorders. There should also be increased range and quantity of in-home and other mental health supports and services for the children, foster parents, biological parents and adoptive parents.

### **Recommendation #24:**

HRS should insure that foster parents are given all information available pertaining to the child at the time of placement into the home so that appropriate medical, mental health and educational services can be established for the child.

### **Recommendation #25:**

Foster parent pre-service and in-service trainings need to focus more on parenting skills needed to work effectively with foster children and their complex needs. HRS must insure that all foster parents have met the required 8 hours of in-service training necessary for relicensure. All curriculum and mechanisms for training should be approved by the department and should be directed at improving the capabilities of foster parents.

### **Recommendation #26:**

Public access to foster parent licensing files should be limited to protect the privacy and safety of the children placed in their homes.

### **Recommendation #27:**

Foster parents should be an integral part of the service team and should participate in the development and implementation of the case plan. Having played an integral role in the development of the agreed-upon case plan, the foster parent is obligated to work towards its accomplishment.

### **Recommendation #28:**

A placement staffing should be held within the first 30 days of a child's placement in a foster home to insure that a comprehensive and individualized service plan is put in place. The staffing team should include the biological (and

extended) family, foster family, foster care staff, school personnel, and medical and mental health providers who are a part of the child and family's service plan.

### **Recommendation #29:**

HRS should work closely with state health care organizations (FMA, FOMA, FNA, FHA) and the court system to better define the parameters of consent for health care services for foster children in order to streamline access to essential medical services. HRS should work closely with foster parents to better define their authority to secure timely health care services for children in their home.

### **Recommendation #30:**

Communities need to make all available resources known that offer services to children and families through brochures and various other mediums of communication.

### **Recommendation #31:**

The laws pertaining to monitoring of home education (home schooling) should be revised to insure that the student is making adequate educational progress, including assessment of the child by the local school district.

### **Recommendation #32:**

HRS contracts with medical and mental health providers should require timely and comprehensive reports on the care of foster children.

### **Recommendation #33:**

The courts and HRS should cooperate in scheduling hearings and caseworker court appearances to enhance caseworker productivity.

### **Recommendation #34:**

HRS should coordinate services in domestic violence cases that would focus support for the non-abusing parent to prevent the removal of children.

### **Recommendation #35:**

The Supreme Court should review the Guardian Ad Litem program statewide to assure a level of effectiveness and accountability which protects the interests of children under their jurisdiction.

### **Recommendation #36:**

The state HRS and each district should examine new outcome-based approaches to partnerships between state agencies and the private sector (i.e., to contract for specific outcomes, rather than piecemeal services).

### **Recommendation #37:**

Since approximately half of the foster children who present special challenges are ultimately adopted by their foster parents, the standards for the screening, selection, and preparation should be identical for foster and adoptive parents. This should include such things as fingerprinting, adoptive parent's health history, etc. HRS and the community should increase their efforts to recruit and retain adoptive parents through special campaigns that are supported by adequate resources. HRS should establish criteria for ongoing receipt of adoption maintenance subsidies (i.e., children should be in school, receive medical care).

### **Recommendation #38:**

An integrated system of child care needs to be established throughout the state. Mental health, substance abuse, and domestic violence services should be funded, made more accessible, and offered in a more timely fashion to better serve our children and families.

### **Recommendation #39:**

There should be cross training of staff in child protection, mental health, domestic violence and substance abuse directed toward the development of comprehensive and individualized case plans and services for children and families.

# Conclusion

**A**fter reviewing the circumstances surrounding the tragic death of Lucas Ciambrone, the panel concludes that there were a number of errors in the handling of this case. The primary conclusion of the panel, however, is that the child protection system overall continues to be an overburdened system called upon to provide critical services to an increasingly vulnerable population, despite the fact that the system has undergone a number of positive changes in recent years. Because the overall system is so overburdened, it is inevitable that there will be more tragedies, like Lucas, and many, many more youngsters whose wounds will not be as visible or extreme as Lucas' but who will needlessly suffer emotionally and physically.

The Panel has made recommendations that not only address circumstances of Lucas' death, but address systemic problems that affect many more children who now or in the future may be in Lucas' situation. The Panel has concluded that the present funding for child protection in Florida is inadequate, and has recommended additional funding. The Panel has also recommended that the child welfare workforce be strengthened, that quality assurance and accountability procedures be improved, and that realistic limits be established and followed for the number of children in any foster home.

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*Present funding for child protection in Florida is inadequate.*

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Further, the Panel concluded that significant progress in protecting Florida's children will only come when new partnerships are formed between state and local agencies, HRS and the local communities. HRS has increased its efforts in recent years to reach out and establish such partnerships with local communities, and the Panel recommends that these efforts continue. Ultimately, the responsibility for the safety and well-being of children must be a shared one, built upon the strengths, talents, and commitment of local citizen groups, churches and synagogues, the business community, law enforcement, advocacy organizations, the media, schools, and health and social service agencies.

# **List of Panel Members and Biographies**

## ***Colleen Lunsford Bevis***

Colleen Lunsford Bevis has been an advocate for children for 45 years. She was a leader in the effort to encourage the Hillsborough County voters to establish the Children's Board and was appointed to that Board by Governor Chiles in 1992. In 1993 the Hillsborough County Commission appointed her to the District 6 Health and Human Services Board, where she chairs the Committee on Children and Families.

## ***Ray Ciemniecki***

Ray Ciemniecki is the Principal of Adult and Community Education in Manatee County. Ray was formerly the Director of Student Services and Exceptional Student Education with Manatee County Schools, 1977-95; Degrees: B.A. - Elementary Education and Special Education; M.A. - School Psychology; M.Ed. - School Administration; Affiliations: Past Co-chairperson, HRS District VI Nominee qualifications Review Committee to select members for the District VI Health and Human Board; Past President, Florida Association of Student Services Administrators; Past President, Manatee Council for Exceptional Children; Past Chairperson, Florida Association of School Administrators, Legislative Committee; Past Board Member, Florida Council of Administrators of Special Education; Past Chairperson, Manatee Juvenile Detention Advisory Board.

## ***Robert M. Friedman***

Dr. Friedman is a clinical psychologist who has specialized in research and policy analysis for children and families. Dr. Friedman received his B.A. from Brooklyn College, and his M.S., and Ph.D. from Florida State University.

Dr. Friedman is currently Professor and Chair of the Department of Child and Family Studies, at the Florida Mental Health Institute, University of South Florida. The Department of Child and Family Studies is a multi-disciplinary department with approximately 30 faculty members and 120 staff which strives to improve the well-being of families and children through applied research, training and education, and dissemination of information.

Dr. Friedman also serves as Director of Research and Training Center for Children's Mental Health. The Research and Training Center is one of two such centers nationally, and is funded by the National Institute on Disability and Rehabilitation Research and the Center for Mental Health Services.

Dr. Friedman is a researcher, author, policy analyst, and consultant on issues such as clinical services for children and families, the development and evaluation of community-based systems of care, collaborations between mental health and child welfare systems, and prevalence of emotional disorders.

Dr. Friedman has published and presented more than 125 papers and articles. He is co-author with Beth Stroul of "A System of Care for Severely Emotionally Disturbed Children and Youth," which has been widely used across the country to plan services for children with emotional disorders and their families. He is also co-editor of a special edition of the Journal of Mental Health Administration on children's mental health services, and co-editor of a book entitled "Advocacy on Behalf of Children with Serious Emotional Problems."

Dr. Friedman has consulted with more than 40 states, and several federal agencies, has testified before Congressional committees, and has either been a grant recipient or advisor to several major private foundations. His current research includes multi-site systems evaluations, longitudinal epidemiological studies, and analyses of the service needs of children in child welfare, mental health, education, and juvenile justice systems.

## ***Jack Lockett***

Jack Lockett served as a Peace Corps staff member both overseas (Nepal) and in Washington, D.C., where he was responsible for the training of all volunteers serving in North Africa, the Near East and South Asia. Directed a Community Center in Perth Amboy, NJ where he was involved in developing an Alternative School for actual and potential high school dropouts, a Storefront College for adults seeking post-secondary education and a Career Intern Program for youth. In 1978, joined Save the Children, an international organization committed to improving the quality of life of children and their families through self-help, community development, projects. Held various senior level positions in both their overseas and domestic operations. Retired in 1991 and moved to Florida. In 1993 was appointed a member of the Health and Human Services Board serving Pasco and Pinellas counties. Also served as the Interim Chief Administrator of the Children's Board of Hillsborough County for one year while they conducted a national search for a permanent Executive Director.

## ***Charles S. Mahan, Co-Chair***

Charles S. Mahan is Dean of the College of Public Health and Professor of Obstetrics and Gynecology at the University of South Florida. He was raised in West Virginia and received his MD degree from Northwestern and did his residency training at the University of Minnesota where he returned to join the faculty. He moved to Florida in 1974 to be Director of Ambulatory Services for Women at the University of Florida and Director of the North Central Florida Maternal and Infant Care Program. He has been Professor of Obstetrics and Gynecology at the University of Florida College of Medicine since 1974. He was State Health Officer from 1988 to 1995. He is immediate past president of the Association of State and Territorial Health Officials and currently serves on the Advisory Committee to the Director of the Centers for Disease Control and Prevention and on the HHS Secretary's Advisory Committee on Infant Mortality.

## ***James E. Mills***

Mr. Mills has been the Executive Director of the Juvenile Welfare Board of Pinellas County, Florida since 1983. The Juvenile Welfare Board is the nation's first independent taxing district whose proceeds are dedicated solely to provision of services to children and families. In addition to contracting for a wide variety of children's services, the Juvenile Welfare Board also conducts active programs of advocacy, community planning, service coordination, staff development and training, and technical assistance to community groups and social agencies. Since passage of statewide enabling legislation in 1986, Mr. Mills has been active in efforts to establish Juvenile Welfare Boards throughout the State of Florida.

Mr. Mills came to Florida from Sacramento, California in 1983, where for eight years he was Executive Director of the Community Services Planning Council. In addition to a wide range of community planning responsibilities, the Community Services Planning Council operated the Area Agency on Aging for Sacramento and six surrounding counties.

After receiving his master's degree in social work from the University of Connecticut, Mr. Mills held a variety of professional and administrative positions, including Chief of Direct Services, Milwaukee Region, Division of Family Services, Wisconsin Department of Health and Social Services; Director of Children and Family Services, United Way of Milwaukee; and Deputy Director of the Wisconsin Council on Criminal Justice.

He has experience in the fields of child welfare, criminal justice, aging and community planning in both the public and voluntary sectors.

Mr. Mills is active in the National Association of Social Workers, was the first president of the Wisconsin Chapter and served as both Treasurer and Vice President for Community Services for the California Chapter. He was named Florida Social Worker of the Year in 1989 and received the Leadership St. Pete Alumni Association Community Service Award in 1994. Mr. Mills served as the first Chairperson of the Florida Children's Council. He has served as President of the National Network of Social Work Managers and has also been actively involved

with the Child Welfare League of America and a number of other state and national professional organizations, task forces and community groups.

Mr. Mills served on the Governor's Child Welfare Task Force in 1986 (Florida) and Social Services Transitional Task Force (1990) and previously chaired the Interagency Committee on Planning and Evaluation (I-Cope) in Pinellas County for three years.

Mr. Mills has lectured at the University of Wisconsin (Milwaukee), California State University (Sacramento) and the University of California (Davis, Extension Division).

### ***Jon Parsons***

Jon Parsons has been the Executive Director of the Children's Home, Inc., for the past 18 years. Jon has his master's degree in social work from Case Western Reserve University and is currently clinical assistant professor for the University of South Florida in the Department of Psychiatry and Behavioral Medicine.

### ***L. David De La Parte, Co-Chair***

David received his Bachelor's degree in political science from Florida State University in 1983 and his Juris Doctor from Stetson University College of Law in 1985. David is a shareholder and partner with the law firm of de la Parte, Gilbert & Bales and has an established practice primarily in administrative, transactional and governmental law. He is principally responsible for the firm's health care clients and for commercial and real estate transactions for the firm's private and governmental clients. David is currently general counsel to the H. Lee Moffitt Cancer Center and Research Institute, a non-profit teaching and cancer research hospital on the campus of the University of South Florida, and the Florida State Pilots Association, a state association of harbor pilots. David also represents a number of physician groups and individual physicians. In addition, a significant aspect of David's practice includes representation of governmental and quasi-governmental agencies.

David was admitted to The Florida Bar, the United States District Court for the Middle District of Florida, and the United States Court of Appeals for the Eleventh Circuit in 1986, and was admitted to the United States Supreme Court in 1993.

David is a member of the American and Florida Bar Associations and is currently the chairman of the Hillsborough County Bar Association Health Law Section. He is also a member of the National Health Lawyers Association and the Florida Hospital Association.

David currently serves as chairman of the District 6 Health and Human Services Board for Hillsborough and Manatee counties and serves on the Board of Directors of the Associated Marine Institute, a private, not-for-profit organization which establishes and operates programs for the rehabilitation of delinquent youth. David is also chairman of the Board of Directors of the Tampa Marine Institute, a non-residential juvenile delinquency program, and Youth Environmental Services, a residential juvenile delinquency program. David is a member of the Greater Tampa Chamber of Commerce, University of South Florida Presidents Council and the United Way Keel Club.

### ***Connie Shingledecker***

Captain Connie Shingledecker is an 18-year veteran law enforcement officer with the Manatee County Sheriff's Office. She has a background in patrol, criminal investigations, child abuse investigations, and her current assignment is Patrol Commander.

Captain Shingledecker is actively involved in the community in the areas of domestic violence, child abuse, and juvenile justice. She is a member of numerous boards and is considered a child advocate.

### ***Sally Smith***

Dr. Sally Smith is a Pediatrician at All Children's Hospital. She received her education at Georgetown University and St. Louis University School of Medicine. Following her Pediatric post doctoral training at All Children's Hospital and at St. Louis University School of Medicine, Dr. Smith has practiced general academic pediatrics since 1988. She was Assistant Professor of Clinical Pediatrics at UMDNJ

- Robert Wood Johnson Medical School from 1988 to 1990. She then joined the General Academic Pediatric Faculty at All Children's Hospital in July 1990. Her responsibilities at the hospital include directing Ambulatory Education for the teaching program at the hospital. She also has been a Pediatric Consultant for the Suncoast Child Protection Team since 1990. Prior to that time she was Director the Sexual Abuse Management Program at UMDNJ. Dr. Smith has been interested in gaining experience and expertise in evaluation of child abuse since medical school and has focused much of her continuing medical education in this area. She has given numerous seminars and lectures on child sexual abuse, child physical abuse, patterns and recognition of child abuse, shaken baby syndrome, and Munchausen syndrome by proxy to physicians as well as many other professionals who are involved in child protection.

# **Panel Meeting Dates and Locations**

August 22, 1995	Florida Mental Health Institute, Tampa, Florida
August 31, 1995	Pinnacle Plaza Office Complex, Bradenton, Florida
September 13, 1995	Quality Suites Hotel, Tampa, Florida
September 18, 1995	Pinnacle Plaza Office Complex, Bradenton, Florida
October 5, 1995	Office of Parole and Probation Services, Tampa, Florida
October 17, 1995	City Hall, Bradenton, Florida
November 6, 1995	Office of Parole and Probation Services, Tampa, Florida
November 15, 1995	Office of Parole and Probation Services, Tampa, Florida
November 29, 1995	Office of Parole and Probation Services, Tampa, Florida
December 12, 1995	Holiday Inn, Bradenton, Florida
December 20, 1995	Florida Mental Health Institute, Tampa, Florida
January 8, 1996	Florida Mental Health Institute, Tampa, Florida

# **Table of Documents Received by the Panel**

1. Ciambrone Foster Home Chronology
2. L. C. Chronology
3. State Laws, Rules, Policies and Procedures
4. Foster Care Youth Exit Interviews
5. Addendum to State Laws, Rules, Policies and Procedures
6. History of the Florida Abuse Hotline
7. Hotline Chronology, July 1993 - September 1995
8. Annual Report of the Florida Hotline
9. District 6 Alternate Care Plan
10. Reporting Health/Safety Hazards in Residential Care. District  
Operating Procedure HRSM 175-8
11. Foster Parent Conversion. District Operating Procedure  
HRSM 175-16
12. DMS/HRS Classification and Compensation System
13. Statewide Review of Children in Foster Care
14. Child Welfare League of America 1990 Salary and Retention  
Study
15. Department of HRS Organizational Chart
16. District 6 Organizational Chart
17. Child Welfare Service System Flow Charts ( 1 - 3)
18. Exit Review, District 6, Department of HRS

19. Manatee County Organizational Chart
20. Child Protection Staff Turnover Rates
21. Foster Care Caseloads
22. Protective Supervision Caseloads
23. Protective Investigators Caseloads
24. Comments and Concerns of Manatee County Foster Parents
25. Improvements in Florida's Child Welfare System
26. The Adoption Process
27. Graph of the Adoption of Foster Children by Foster Parents  
1990 - 1995
28. The Department's Post Adoption Services
29. Listing of Active Foster/Shelter Homes in Manatee County,  
Licensed Capacity, Occupancy
30. The Advocate, A Newsletter on Children's Issues
31. Policy Development for Children and Family Services
32. Entry-Level and Supervision Training Curriculum
33. 9-Month Entry Level Core Training
34. Position Description Protective Investigations
35. Position Description Protective Supervision
36. Position Description Foster Care
37. Position Description Adoptions
38. Position Description Family Services Specialist
39. Entry-Level Training Curriculum For C & F Staff Skills and  
Subskills
40. State Comparisons of Child Welfare Staff

41. Letter from Kathy Kimball, Department of HRS, District 6, Foster Care Counselor
42. Human Services Licensing - Statement of Purpose
43. Licensing's Contribution to the Prevention of Child Abuse
44. Licensing Variations
45. Recommendations of Past Commissions on Child Welfare Issues; A Compilation of the Cory Greer, Bradley McGee, 1990 Child Welfare Salary and Retention Study, and the Barkett Commission
46. Hull House Association Neighbor to Neighbor Foster Care Program
47. Report from the Deans of the Schools of Social Work
48. The Becker Workgroup, Recommendations for Changes in Positions Classifications and Pay Grades
49. Children Lost Within the Foster Care System: Can Wraparound Service Strategies Improve Placement Outcomes?
50. Individualized Service Strategies for Improving Outcomes for Children with Emotional/Behavioral Disturbances in Foster Care.
51. Recommendations, Fostering Individualized Assistance Project (FIAP).
52. HRS District 6, Manatee County, Review of the Death of Lucas Ciabrone
53. Improvements to Foster Care System in Manatee County, District 6
54. Letter from Megan Orr, Department of HRS, District 6, Foster Care Supervisor

- 55. Letter from GiGi Nousianen, Department of HRS District 6,  
Child Welfare Trainer
- 56. Manatee County Guardian Ad Litem Training Curriculum
- 57. Guardian Ad Litem Case File on the Ciambrone Children
- 58. Photographs of Lucas Ciambrone taken by the Manatee  
County Sheriff's Department

# Attachment

## Child Watch Visitation Program

*Earlier today, as we started this tour, someone called us the movers and shakers of the religious community. After this experience, we are the moved and the shaken.*

These powerful words were spoken by Archbishop John Roach after his participation in a Child Watch Visitation Program in Minneapolis, Minnesota. All over the country, community leaders like Archbishop Roach are being shaken up by the things they see and hear, and by the children and families they meet through the Child Watch program.

Every 11 seconds, an American child is reported abused or neglected...Every 71 seconds, an American child runs away from home...Every 53 minutes, an American child dies from poverty...Every 2 hours, a child is murdered. These statistics may receive a concerned nod from an elected official or a corporate leader, but it is hard to feel passionate about numbers. It is difficult to put your arms around phrases like "one in every five." But it is hard not to feel passionate about a one-pound infant you see struggling to survive, an infant too small to wrap your arms around. Child Watch supplements the all important facts with the passion they lack.

The Child Watch Visitation Program was designed by the Children's Defense Fund to allow our leaders to see first-hand what is happening to our children. Child Watch adds the faces and stories of real children to the statistics and reports. Organized by volunteers and advocates in local coalitions across the country, Child Watch programs move executives, clergy, legislators, and other community leaders out of their offices, corporate boardrooms, and legislative chambers, and into the world of the real children and families whose lives they affect every day with their decisions. Child Watch programs include four major components:

on-site visits to programs serving children and families; briefings by public policy experts and others; written background materials; and experiential activities.

Together, these four components combine to serve as a comprehensive tool to educate community leaders about children's issues and motivate them toward action. Everywhere Child Watch is used, it helps children and families by building awareness, creating new leadership, and inspiring action.

Through Child Watch, we unveil a picture of children and families that many community leaders have never before seen, and one on which they cannot easily turn their backs. We allow leaders to see that while the situation for many children is critical, there are also wonderful programs, dedicated caregivers, and great hopes for the future. Child Watch gives local program coordinators and participants alike the opportunity to see, hear, feel, and touch children in their communities.

Child Watch not only shocks participants with what they see and hear, but also empowers those participants with the knowledge that they have the ability to make a difference. At the conclusion of each Child Watch visit, participants do not leave feeling powerless because of the magnitude of the problems they have witnessed, but rather inspired by the endless possibilities of the ways in which they can help.

Each community coalition determines the goals, focus, and format of its local Child Watch program. Child Watch in Los Angeles has exposed a wide range of religious leaders to the issues facing adolescents. Corporate executives in Kansas City have visited day care and Head Start centers as a part of their Child Watch experience. In Flint, elected officials join other community leaders as participants in Child Watch programs visiting homeless shelters, hospitals, and drug treatment facilities.

While the area of focus may vary from community to community, the ultimate goal of every Child Watch program is the same to improve the lives of children by promoting action on the local, state and national levels. Child Watch participants learn that every individual, congregation, organization, and business is powerful. Each can, and must, make a difference for children in their communities and across the country.

Civic, religious, philanthropic, and community groups from across the country are active members of Child Watch coalitions. Involvement in Child Watch gives organizations an opportunity to work collaboratively with others in their communities, learn more about the status of children and families, and play a key role in improving their lives. For more information about Child Watch activities in your area and how you can get involved, please call Colleen Montoya at 202/662-3588.

# Costs Associated with the Child Watch Visitation Program

The Children's Defense Fund (CDF) is committed to providing comprehensive, high-quality training and technical assistance services to the local coalitions we serve. The Child Watch Division of CDF will assume the cost of the following services:

- ◆ One Coalition Building Packet, designed to assist coalitions in the beginning stages of the Child Watch planning process;
- ◆ One on-site implementation workshop conducted by a Child Watch trainer;
- ◆ Training packets for all those attending the workshop;
- ◆ One Child Watch Implementation Manual, outlining the steps necessary to implement a program on the local level;
- ◆ One Sample Materials Appendix, a compendium of Child Watch materials developed by coalitions across the country;
- ◆ One complementary registration to the Child Watch Presession of CDF's Annual Conference (this *does not* cover transportation, accommodation, or general conference registration fees); and
- ◆ The inclusion of one member of your coalition on the monthly Child Watch mailing list, including quarterly issues of *The Child Watch Update*.

While limited funding restricts our ability to provide multiple sets of Child Watch materials, we encourage coalitions to duplicate these materials as needed. Because we strive to reach as many communities as possible with our limited grant dollars, we provide the following additional services at a small fee to cover our costs:

- ◆ Additional copies of the Child Watch Implementation Manual at \$5.00 per copy;
- ◆ Additional copies of the Sample Materials Appendix at \$15.00 per copy;
- ◆ Additional Child Watch Presession registrations at \$25.00 per person; and
- ◆ Additional coalition members added to the monthly mailing list at \$20.00 per person.

Child Watch coalitions with the financial resources available to help underwrite training and technical assistance services provided by the Child Watch Division are encouraged to do so.