Special Review of the Case Involving

Jordan Belliveau Jr.

Florida Department of Children and Families
January 11, 2019

Special Review of the Case Involving Jordan Belliveau Jr.

Suncoast Region
Circuit 6
Pinellas County, Florida
2018-632408

Table of Contents

Executive Summary

On September 5, 2018, the department received a report regarding the death of two-year-old Jordan Belliveau Jr., whose body was found deceased in a wooded area in Largo, Florida, the previous day. The discovery was made two days after an Amber Alert was issued when his mother, 21-year-old Charisee Stinson, reported him missing. Initially, Ms. Stinson claimed that she was assaulted by a stranger after which time Jordan's whereabouts became unknown as she reportedly lost consciousness during the alleged altercation. However, she subsequently admitted to fabricating the events surrounding Jordan's disappearance and confessed to causing the injuries that ultimately resulted in his death.

At the time of the incident, the family was under court-ordered protective supervision as Jordan, who had been removed from his parent's custody in October 2016, was reunified with Ms. Stinson in May 2018. In addition to the open service case, there was also an active child abuse investigation due to on-going domestic violence between Ms. Stinson and Jordan's father, 22-year-old Jordan Belliveau, Sr.

Given these circumstances, Interim Secretary Rebecca Kapusta immediately initiated a special review to evaluate the circumstances surrounding Jordan's death and to assess the level of service intervention that had been in place during the course of his 17-month removal episode and continuing upon his reunification with Ms. Stinson in May 2018.

The review team consisted of representatives from the following agencies: DCF's Office of Child Welfare, Northwest Region and Suncoast Region; Pasco County Sheriff's Office Child Protective Investigations Division; CBC of Central Florida (community-based care provider in the Central Region); and the Guardian ad Litem's Office. Additional team members included the Interim Director for Substance Abuse and Mental Health (SAMH) from the Central Region, a sworn law enforcement officer from the Tampa Police Department, a former domestic violence advocate from the Broward County Sheriff's Office Child Protective Investigations Division, Children's Legal Services Regional Director and Statewide Training Director from the Suncoast Region, and Child Protection Team medical director from the Southern Region.

The review process was conducted using a multi-faceted approach:

The team's child welfare experts completed a review of available records, including prior child abuse investigations; case management files; and dependency court records (including listening to audio recordings of the court hearings). In addition, interviews were conducted with staff from the Pinellas County Sheriff's Office Child Protective Investigations Division, Eckerd Connects (formerly Eckerd Community Alternatives - lead community-based care agency), Directions for Living (contracted case management organization [CMO] for Eckerd Connects), the State Attorney's Office (which provides Children's Legal Services in Circuit 6), the Guardian ad Litem's Office, and Jordan's former foster parents.

The team's mental health expert completed a review of all available clinical records with emphasis on the various behavioral health evaluations/assessments performed (inclusive of the treatment records) and conducted an interview with the provider.

The law enforcement expert completed a review of all available law enforcement reports (including, but not limited to incident reports, arrest affidavits, and call out logs) to assess the response of the various law enforcement agencies involved.

Findings:

A. Based on the information in the record, the decision to reunify Jordan was driven primarily by the parents' perceived compliance to case plan tasks and not behavioral change. There was a noted inability by all parties involved to recognize and address additional concerns that became evident throughout the life of the case (e.g., on-going domestic violence between the parents; and probable substance abuse and mental health issues). Instead, case decisions were solely focused on mitigating the environmental reasons Jordan came into care (e.g., the gang and drug activity associated with the paternal grandmother's home where Jordan and Ms. Stinson were residing) and failed to address the overall family conditions.

B. Following reunification, policies and procedures to ensure child safety and well-being were not followed, in accordance with 65c-30.014 FAC "Post-Placement Supervision and Services" and CFOP 170-7, Chapter 12 "Implement Reunification and Post-Placement Supervision." In addition, there was a noted lack of action taken by case management staff concerning Ms. Stinson's lack of compliance and her failure to participate with the reunification program prior to and following reunification.

C. When the new child abuse report was received in August 2018, alleging increased volatility between the parents, present danger was not appropriately assessed and identified. The child protective investigator's (CPI) assessment was based solely on the fact that the incident wasn't reported to the Florida Abuse Hotline when it initially occurred. The CPI failed to identify the active danger threats occurring within the household that were significant, immediate, and clearly observable. Given the circumstances, a modification of Jordan's placement should have been considered.

D. Despite the benefit of co-location, there was a noted lack of communication and collaboration between the Pinellas County Sheriff's Office CPID unit and Directions for Living case management staff in shared cases involving Jordan and his family, especially regarding the August 2018 child abuse investigation.

E. In addition to the lack of communication and collaboration between frontline investigations and case management staff noted in the above bullet, there was an absence of shared ownership between all entities involved throughout the life of Jordan's case which demonstrates a divided system of care. In addition, the lack of multidisciplinary team approach resulted in an inability to adequately address the identified concerns independent of one another.

F. The biopsychosocial assessments failed to consider the history and information provided by the parents and resulted in treatment plans that were ineffective to address behavioral change. Moreover, there was an over-reliance on the findings of the biopsychosocial assessments as to whether focused evaluations were warranted (e.g., substance abuse, mental health, domestic violence, etc.), despite the abundance of information to support such evaluations were necessary.

Introduction

On September 5, 2018, the department received a report regarding the death of two-year-old Jordan Belliveau Jr., whose body was found deceased in a wooded area in Largo, Florida, the previous day. The discovery was made two days after an Amber Alert was issued when his mother, 21-year-old Charisee Stinson, reported him missing. Initially, Ms. Stinson claimed that she was assaulted by a stranger after which time Jordan's whereabouts became unknown as she reportedly lost consciousness during the alleged altercation. However, she subsequently admitted to fabricating the events surrounding Jordan's disappearance and confessed to causing the injuries that ultimately resulted in his death.

At the time of the incident, the family was under court-ordered protective supervision as Jordan, who had been removed from his parent's custody in October 2016, was reunified with Ms. Stinson in May 2018. Jordan was last seen by his case manager on the evening of August 31, 2018, the day before he was reported missing. In addition to the open service case, there was also an active abuse investigation due to on-going domestic violence issues between Ms. Stinson and Jordan's father, 22-year-old Jordan Belliveau, Sr.

Between October 2016 and August 2018, there were three reports involving Ms. Stinson and Mr. Belliveau, and their only child, Jordan. The first report in 2016 resulted in Jordan's removal and placement in licensed foster care. The second report in 2017 was received while Jordan was still in foster care, following an incident that occurred while he was on his first unsupervised visit with Ms. Stinson. The third report in 2018 was still an active investigation when Jordan was reported missing and subsequently found deceased. [redacted]

Given these circumstances, Interim Secretary Rebecca Kapusta immediately initiated a special review to evaluate the circumstances surrounding Jordan's death and to assess the level of service intervention that had been in place during the course of his 17-month removal episode and continuing upon his reunification with Ms. Stinson in May 2018. The multidisciplinary team was not only comprised of individuals who specialize in child welfare, but also those with mental health, and domestic violence expertise (both from a treatment and law enforcement perspective) to address the reunification decision and actions that occurred when subsequent concerns were identified.

This report presents the review team's findings, including the child welfare history, the family composition, and a summary of the local child welfare services providers, as well as an analysis of the local system of care.

Case Participants

Name	Age at Time of Incident	Relationship
Jordan Belliveau Jr.	2 years	Decedent
Charisee Stinson	21 years	Mother
Jordan Belliveau	22 years	Father

Child Welfare Summary

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted] After giving birth to Jordan on July 29, 2016, at the age of 19, Ms. Stinson was offered extended services [redacted]; however, she declined any additional support.

The first report involving Ms. Stinson and Mr. Belliveau as caregivers was received in October 2016, when Jordan was only three months of age, due to concerns about the home environment where Jordan was residing. At the time, Jordan and his parents were living in the home of the paternal grandmother, along with Mr. Belliveau's other siblings. Allegations included concerns for drugs and firearms in the home in addition to gang involvement on the part of Mr. Belliveau and his siblings. In addition, the home had been the location of gun-related incidents on at least three

occasions which were alleged to be the result of gang-related retaliation against Mr. Belliveau and Jordan's paternal uncle.

Given the unsafe environment of the paternal grandmother's home, a shelter hearing occurred the morning of November 1st, at which time Ms. Stinson was ordered by the court to relocate to a safer environment for both Jordan and herself, and efforts to relocate her to Alpha House of Pinellas County (a program that provides housing and support services to young mothers) were initiated immediately. In addition, the court ordered Mr. Belliveau, the paternal uncle, and another cousin out of the paternal grandmother's home due to the threat of harm that they, along with their gang-involved lifestyle, imposed upon the other younger children in the home [redacted]

Later that same day, Ms. Stinson became uncooperative during her intake interview at Alpha House, which resulted in her not being accepted into the program. For the second time in one day, the case went before the court, at which time Jordan was ordered to be placed in licensed foster care as Ms. Stinson had no other housing option available.

The case was transferred from the Pinellas County Sheriff's Office Child Protective Investigations Division (CPID) to Directions for Living, the contracted case management organization under Eckerd Connects, the lead community-based care agency in Pinellas County. The investigation was later closed with verified findings for environmental hazards and inadequate supervision. At the Arraignment Hearing, Ms. Stinson and Mr. Belliveau consented to the petition and Jordan was adjudicated dependent. Supervised visits were ordered to occur twice weekly between Jordan and his parents, with the CMO retaining discretion to allow for unsupervised visits when appropriate. Ms. Stinson's case plan tasks were for her to obtain/maintain stable housing and income, to comply with a biopsychosocial assessment and follow recommendations based on the assessment, and to cooperate with services. Mr. Belliveau's case plan included the same tasks identified for Ms. Stinson, with an additional requirement for individual counseling.

In mid-January 2017, Jordan's placement in his initial foster home disrupted, and he was moved to another foster home where he remained until he was later reunified with Ms. Stinson the following year.

While Jordan was in licensed foster care, there appeared to be escalating incidents of violence between Mr. Belliveau and Ms. Stinson. On January 19, 2017, Mr. Belliveau was arrested for domestic violence perpetrated against Ms. Stinson. The charges were subsequently dropped when Ms. Stinson declined to prosecute. Although parental visitations were addressed during the Judicial Review hearing on February 27, 2017 and specified that the parents were not to visit with Jordan together while being supervised by a third party due to domestic violence concerns, there was no modification to the case plan to address the identified issue.

On April 2, 2017, Ms. Stinson was arrested for domestic violence perpetrated against Mr. Belliveau, as well as resisting arrest. Like Mr. Belliveau's previous case, Ms. Stinson's charges were subsequently dropped when Mr. Belliveau declined to prosecute. Again, the case plan tasks were not modified and on May 23, 2017, a recommendation was made by case management staff to change Ms. Stinson's visits with Jordan from supervised to unsupervised in the community, which was subsequently approved by the court.

Ms. Stinson's first unsupervised visit occurred on June 18, 2017. Because it was Father's Day, Ms. Stinson planned to allow Mr. Belliveau to also visit with his son at a local Burger King, unbeknownst to the case manager or foster parents. In doing so, Ms. Stinson was in violation of

the visitation order requiring Mr. Belliveau's visits with Jordan to be supervised. While at the restaurant, family members of a rival gang arrived and a fight ensued. Mr. Belliveau was involved in a physical altercation with a female who confronted Mr. Belliveau about an incident between him and her son. As Mr. Belliveau and the other female were fighting, Ms. Stinson jumped in and attempted to strike the female while holding Jordan in her arms. In retaliation, the other female attempted to hit Ms. Stinson and, instead, struck Jordan in the mouth. Both law enforcement and EMS responded to the scene and observed Jordan to have swelling and a small laceration on the inside of his lip. Ms. Stinson refused medical treatment and there was no further action taken, (e.g., no arrests, and no report called to the hotline by first responders at the time of the incident).

Later that day, a report concerning the incident was received at the hotline, prompting an investigation by the Pinellas County Sheriff's Office CPID unit. The report also alleged that Mr. Belliveau was selling cocaine and marijuana from the home, and that both he and Ms. Stinson used the reported drugs "all of the time." During a home visit conducted by the CPI at the mother's residence (which was still at the paternal grandmother's home where Mr. Belliveau was also present), there was a strong odor of marijuana and a marijuana stem was observed on the table. Both Mr. Belliveau and Ms. Stinson denied any drug use, however, they refused to submit to a drug screen.

Jordan was examined by the Child Protection Team (CPT) on June 20, 2017, which concluded that the injury to Jordan's lip was inflicted and resulted when the mother purposely engaged in an altercation with the child in her arms. When interviewed by CPT, the foster mother expressed concerns for Jordan's safety and well-being while visiting with his parents and felt that the visits needed to be supervised, especially since Ms. Stinson failed to mention anything about the altercation that occurred just prior to the foster mother picking Jordan up from his visit. In conclusion, CPT recommended that Jordan's visits with his parents be supervised at a licensed facility and not supervised by family members.

On July 16, 2017, the CPI sent a detailed email to the case manager and case manager supervisor outlining significant concerns, as there had been no response to previous attempts by telephone to discuss the case. The case manager supervisor contacted the CPI by phone the following day at which time the issues in the case were discussed, including the need to drug screen both parents due to concerns of marijuana use and alleged cocaine use. The case management supervisor informed the CPI that drug screens haven't been completed on the parents as it is not a part of their case plan. There was no documented conversation referencing CPT's recommendation that the parents' visitations be supervised and occur at a licensed facility.

On July 20, 2017, the investigation was closed with verified findings for inadequate supervision and failure to protect with both Mr. Belliveau and Ms. Stinson identified as caregivers responsible. Documentation does reflect that Ms. Stinson's visitation plan was addressed with both the State Attorney and the case manager and it was recommended that the mother's visits be changed back to supervised following the incident at Burger King. Beyond the initial request by the CPI, drug screens were never conducted on the parents, although the issue was communicated to both the attorney and case manager regarding the need to do so.

A Judicial Review hearing occurred on July 31, 2017, at which time the June abuse report was discussed. In her testimony, Ms. Stinson minimized what had occurred and the court was led to believe that the events were something other than a violent gang-related altercation. There was no mention of Ms. Stinson's involvement in the fight or the fact that Jordan was injured during the

altercation. Moreover, there was no discussion about CPT's findings and the recommendation that the parents' visits be supervised at a licensed facility; or any request for a substance abuse evaluation or drug screens given the concerns for substance use by both parents. Despite the known information, no objections were voiced when the court gave the CMO discretion to allow the parents supervised visitation together and for Ms. Stinson to have unsupervised and overnight visits.

On October 31, 2017, a permanency staffing occurred with case management staff and the parents in attendance. At the time, Ms. Stinson had been terminated from individual counseling due to her lack of attendance, and Mr. Belliveau had not yet completed any of his assigned tasks. When asked about their lack of compliance, Ms. Stinson reported that it was her work schedule that impeded her ability to attend counseling, and Mr. Belliveau noted that he hadn't been able to do anything because he reportedly lost his ID. Approximately one week later, the State Attorney filed multiple reports with the court that included, but was not limited to, the domestic violence arrest incidents involving both parents, 9-1-1 calls to the home, the verified abuse report from June as well as the corresponding CPT report, and the permanency staffing notes that detailed the concerns.

Mr. Belliveau subsequently completed his biopsychosocial assessment on November 28, 2017. During his assessment, Mr. Belliveau was very forthcoming and open about [redacted] however, he was not referred for any additional evaluation [redacted] to address the diagnostic issues identified.

On December 19, 2017, at the request of his foster parents, a Guardian ad Litem was appointed to the case, 13 months after Jordan's removal had occurred.

At the Judicial Review hearing on January 8, 2018, the court noted that the case was past permanency and that the mother had still not obtained housing. While Mr. Belliveau was found to be non-compliant with his case plan tasks, Ms. Stinson was found to be partially compliant as she had completed her biopsychosocial assessment and she reported to be participating in counseling. Because Ms. Stinson was found partially compliant with her case plan tasks, the court found compelling reason to not consider termination of parental rights per 39.8055(2), Florida Statutes. It should be noted, however, that while Ms. Stinson had reportedly re-engaged in counseling on December 7, 2017, she was again, failing to attend scheduled sessions.

On February 20, 2018, a home study was conducted on Ms. Stinson's new residence; however, was denied due to Mr. Belliveau residing in the home. This would be addressed further during the status hearing six days later.

During a Status Hearing on February 26, 2018, reunification was denied due to Mr. Belliveau living in Ms. Stinson's home. The court discussed the 9-1-1 calls concerning domestic violence which Ms. Stinson claimed to be harassment calls made by another individual. Instead, the court ordered that Ms. Stinson be allowed unsupervised visits in the community without the father present. The CMO was given discretion to allow for Ms. Stinson to have overnight visits and discretion to allow Mr. Belliveau to have unsupervised and overnight visits, and for the parents to visit together. Case notes also reflect that the court gave the agency discretion to allow Mr. Belliveau to move into Ms. Stinson's home; however, that is not supported by the audio recording of the court hearing. Aside from the 9-1-1 calls, there was no other discussion about the on-going

domestic violence between Mr. Belliveau and Ms. Stinson, or the need to modify their respective case plans to ensure all issues were being addressed. Additionally, because Mr. Belliveau's biopsychosocial assessment was previously submitted to the court on January 12, 2018, there was evidence to support the further need for [redacted] however, the evaluator did not recommend [redacted] and it was never addressed in court. On March 1, 2018, Mr. Belliveau was successfully discharged [redacted]

On April 5, 2018, a staffing was held between case management staff, Mr. Belliveau, Ms. Stinson, the family support worker, Guardian ad Litem (GAL) and foster mother, as Mr. Belliveau's attorney had filed a motion for unsupervised visits. All parties agreed that Mr. Belliveau should have unsupervised visits. Mr. Belliveau's first unsupervised visit occurred on April 15, 2018.

On or about April 12, 2018, the service case was transferred to a new case manager, however, it remained in the same unit under the previous supervisor.

On April 18, 2018, there was an internal consultation that involved case management staff, Ms. Stinson, the foster mother, and GAL. The primary discussion centered around Ms. Stinson's background check before overnight visits would be recommended. The GAL agreed with overnight visits contingent upon her observing another visit between Ms. Stinson and Jordan (the observation occurred, and no concerns were noted). Staffing participants were apparently unaware that Ms. Stinson had been terminated from counseling the previous day. This was her second termination due to her lack of attendance.

A status hearing was conducted on April 23, 2018, at which time reunification with Ms. Stinson was discussed. Again, the primary issue focused on Ms. Stinson's background checks and the need to obtain specific information. When listening to the audio recording of the court hearing, concerns were raised regarding whether the mother's counseling had addressed the issues as it appeared Ms. Stinson had not fully remedied the circumstances that brought the child into care. However, when the court repeatedly asked for specifics, none were voiced. Ms. Stinson's attorney informed the court that Ms. Stinson had completed her counseling, when in fact, she had been terminated from counseling services for the second time, a week before the hearing occurred due to her lack of attendance. The court found that there was a lack of diligence on the part of the case management agency and GAL to obtain documentation (since it was the second status hearing set where no documentation had been obtained) and then voice an objection to reunification without giving specifics (e.g., concerns about Ms. Stinson's counseling). However, the court required no documentation to support that Ms. Stinson had, in fact, completed counseling as reported by her attorney.

The court ordered that reunification with Ms. Stinson should occur given her perceived compliance with her case plan tasks and gave all parties 20 days to object, should additional information be obtained to support otherwise. No objection was ever filed by any party involved in the case and Jordan was subsequently reunified with Ms. Stinson on May 31, 2018, the day after the signed order was received.

Prior to reunification, Ms. Stinson was referred to an in-home reunification program on April 25, 2018, which included twice weekly visits with a licensed clinician to assist with the reunification transition. It is important to note that Ms. Stinson missed three of her five scheduled visits prior to reunification occurring, which is consistent with her lack of engagement and attendance with

previous counseling services. Following reunification, Ms. Stinson missed seven of 11 visits with the clinician, again showing a consistent lack of compliance, and further demonstrating an absence of behavioral change. Moreover, attending only six of 16 scheduled sessions with the reunification calls into questions any type of behavioral change. She was eventually unsuccessfully discharged from the reunification program on July 24, 2018 due to her lack of participation.

During a Judicial Review/Permanency hearing on June 11, 2018, the court granted reunification as to Mr. Belliveau. Based on the audio recording of the hearing, there appeared to be confusion and misinformation with regards to Ms. Stinson and Mr. Belliveau's compliance with the reunification therapist. At the time of the hearing, Ms. Stinson had already missed or cancelled several appointments, including on May 31, the day that Jordan was physically reunified. On the occasion that Ms. Stinson did meet with the therapist, Mr. Belliveau was only involved in three of the sessions. However, case management and the State Attorney reported that both parents were cooperating and compliant with services. The GAL referenced the on-going domestic violence between the parents and requested for the reunification therapist to address the issue with the parents but indicated that the GAL had observed the parents with the child and they were both cooperative and appropriate. The court directed the case manager to make sure that domestic violence was being addressed. There were no objections voiced regarding Mr. Belliveau's reunification or regarding Ms. Stinson's continued custody of Jordan.

On June 29, 2018, there was a staffing conducted regarding the Rapid Safety Feedback (RSF) review conducted by Eckerd Connects, the lead community-based care agency, two days prior. The identified action items included updating the safety plan and conducting weekly home visits (noting the condition of the home and the sleeping arrangements). A follow-up staffing was completed almost one month later, on July 25, at which time the same action items were identified.

On August 3, 2018, a report was received regarding a domestic violence incident that occurred nearly three weeks prior between Mr. Belliveau and Ms. Stinson, resulting in Mr. Belliveau's arrest. According to the allegation narrative, the incident occurred when Mr. Belliveau went to pick Jordan up and Ms. Stinson reportedly refused to allow him to see the child, resulting in an altercation.

A review of the Largo Police Department law enforcement report, however, indicated the opposite occurred. Law enforcement officials responded to Ms. Stinson's residence late in the evening on July 14, following a 9-1-1 hang-up call. When officials arrived at Ms. Stinson's residence, they observed her with visible swelling, a laceration, and bleeding to her lip which she reported was caused when Mr. Belliveau punched her in the face. The altercation occurred when Mr. Belliveau was attempting to return Jordan to her care at which time she indicated that she was busy braiding her hair and wanted Mr. Belliveau to keep Jordan for a little while longer. Mr. Belliveau became upset, struck Ms. Stinson in the face, and left the residence with the paternal grandmother, leaving Jordan behind with Ms. Stinson.

Law enforcement officials then responded to the paternal grandmother's home where Mr. Belliveau was residing. Mr. Belliveau stated that although Ms. Stinson tried to grab him, he never struck her or placed his hands on her. When the officer questioned Mr. Belliveau about scratches observed along his collar bone, he denied the injuries were caused by Ms. Stinson and stated that he didn't want her to get arrested. Mr. Belliveau then became combative with the officer and stated, "there is going to be a lot of dead cops tomorrow and I'm going to kill that bitch too." Based on the information provided by Ms. Stinson and given her observable injuries, Mr.

Belliveau was taken into custody in the early morning hours of July 15. It's important to note that the incident was not reported to the hotline until August 3.

The abuse investigation was commenced at Ms. Stinson's residence with a joint response by the CPI and Largo Police Department on the afternoon of August 4. At that time, Ms. Stinson refused to answer the door despite numerous attempts. The CPI attempted to call the case manager, however, there was no response; she then called the on-call case manager who advised to call back after discussing the case with the State Attorney's office. The CPI called Mr. Belliveau and paternal grandmother to see if they could convince Ms. Stinson to open the door at which time Mr. Belliveau reported that he was the one who told her not to open the door. The on-call State Attorney was eventually contacted and was informed that Ms. Stinson was not producing the child to which they told the CPI to keep trying to get Ms. Stinson to cooperate and if she continues to refuse, they will go before the court to request an order to produce the child.

In the meantime, Largo Police Department requested additional units to the scene in an effort to get Ms. Stinson to respond. In total, three units were dispatched to the home and officers spent over an hour trying to persuade Ms. Stinson to open the door so that the CPI could see Jordan. Ms. Stinson finally agreed to open the door and allow Jordan to be seen when law enforcement officers began calling her via their PA system. Jordan was observed to be uninjured and no concerns were noted. When interviewed, Ms. Stinson's statement was consistent with the information contained in the law enforcement report. When asked why Ms. Stinson didn't open the door upon the CPI's initial arrival, she stated that she was afraid that Jordan was going to be removed.

Given the on-going and escalating level of violence between the parents, as Mr. Belliveau was now threatening to kill the mother, the inability to control the situation, and the risk of harm posed to Jordan should Mr. Belliveau and Ms. Stinson engage in additional altercations, present danger should have been identified. However, the CPI cited in their present danger assessment that present danger was not being identified solely "based on the late report" of the violent altercation. As a result, there was no consideration for an emergency modification of Jordan's placement and no further action was taken. Moreover, the present danger assessment contradicted the CPI's initial analysis that documented "significant implications based on the history and the fact that the child was just reunified." The incident was further minimized when law enforcement officials classified their involvement as an "Assist Other Agency," and no report was generated.

This investigation remained open and was still an active investigation when Jordan was reported missing and subsequently found deceased.

On August 8, 2018, an unannounced home visit was made by the case manager at which time only Ms. Stinson was home. Approximately five to ten minutes later, Mr. Belliveau along with the paternal grandmother arrived at the residence with Jordan. The case manager addressed the domestic violence incident with both Ms. Stinson and Mr. Belliveau independently of one another. The safety plan was updated; however, it was insufficient to mitigate the danger threats.

On August 17, 2018, an amended case plan was filed with the court, however, had not yet been heard by the time of Jordan's disappearance. The amended case plan included tasks related to the on-going domestic violence issues, to include a Batterer's Intervention Program (BIP) for Mr. Belliveau and a victim's program for Ms. Stinson.

On August 24, 2018, the GAL emailed the case manager due to concerns that Ms. Stinson refused to allow her in the home when she attempted a visit, noting that Ms. Stinson just stood in the doorway.

On August 29, 2018 the CPI emailed the case manager the following:
"Just wanted to touch base with you about the status of this investigation. Have you all addressed the issue with the mother? I did not identify present danger on this one. How often are you visiting with her?" It should be noted that aside from the commencement of the case, this was the first time the CPI had attempted contact with the case manager with regards to the investigation.

The CPI case notes reflect the case manager's response as follows:
"I normally go to the home once a week, however it's hard to get a hold of the mother at times."

Two days later, on August 31, 2018, the CPI sent another email to the case manager asking if there was an amendment to the safety plan in reference to the household violence and if an open services staffing was needed on the case. In addition, the CPI spoke with the assigned attorney from the State Attorney's office who confirmed that he was aware of the new report. The CPI case note also indicates that the GAL was always against reunification (which is not accurate based on the testimony heard in the audio recordings of the court hearings), that Directions for Living (the case management agency assigned to the case) was "for the mother and wanted her to go forward with reunification," and that the case manager left a message today with concerns for making contact with the mother.

Later that evening, the case manager conducted a home visit at Ms. Stinson's residence after multiple unsuccessful attempts to make contact via phone with both parents. While at the home, the case manager asked for Ms. Stinson to call Mr. Belliveau so that he could discuss several issues with them both, including their lack of cooperation with the GAL so that she can see the child. He informed Mr. Belliveau that he was going to be referred to a BIP program, to which he agreed. The case manager also emphasized the continued need for them to participate in services or risk losing custody of Jordan again. During the visit, the case manager observed Jordan to be sleeping in his bed. When the case manager asked Ms. Stinson to wake Jordan, she picked him up from the bed at which time Jordan became fussy and started to cry. She then placed him back down where the child continued sleeping.

Sometime after the case manager left the residence, Ms. Stinson sent a text message to the GAL. In the message, Ms. Stinson apologized for her lack of compliance and promised to do better. She reportedly concluded her message with, "Please don't take my son."

Less than 24 hours later, Ms. Stinson reported Jordan missing.

System of Care Review

This review is designed to provide an assessment of the child welfare system's interactions with the Stinson/Belliveau family and to identify issues that may have influenced the system's response and decision making.

Summary of Findings:

FINDING A: Based on the information in the record, the decision to reunify Jordan was driven primarily by the parents' perceived compliance to case plan tasks and not behavioral change. There was a noted inability by all parties involved to recognize and address additional concerns that became evident throughout the life of the case (e.g., on-going domestic violence between the parents; and probable substance abuse and mental health issues). Instead, case decisions were solely focused on mitigating the environmental reason Jordan came into care (e.g., the gang and drug activity associated with the paternal grandmother's home where Jordan and Ms. Stinson were residing) and failed to address the overall family conditions.

- During a case plan conference on November 23, 2016, Ms. Stinson specifically requested to have anger management; however, this task was never included on her case plan.
- Despite the multiple incidents of domestic violence between Mr. Belliveau and Ms. Stinson, the case plan was never modified, and the noted tasks were insufficient to address the identified needs.
- [redacted]
- On multiple occasions, Ms. Stinson provided false information to the court (e.g., the events surrounding the June 2017 abuse investigation, and her compliance with counseling), which neither the case management agency nor the attorney addressed or clarified to ensure that all information was considered when the court rendered a decision.
- While the court found, and rightly so, that there was a lack of diligence on the part of both the case management agency and GAL to obtain documentation from the provider which would show Ms. Stinson's lack of compliance, the court required no documentation to support that Ms. Stinson had, in fact, completed counseling as she had claimed. The lack of supporting documentation hindered the court's ability to make an informed decision with regards to reunification.
- The court gave all parties 20 days to object to reunification, should additional information be obtained to support otherwise. Although Ms. Stinson had been uncooperative with the reunification program, missing three of five scheduled sessions, no objection was ever filed by any party involved in the case.

FINDING B: Following reunification, policies and procedures to ensure child safety and well-being were not followed, in accordance with 65c-30.014 FAC "Post-Placement Supervision and Services" and CFOP 170-7, Chapter 12 "Implement Reunification and Post-Placement Supervision." In addition, there was a noted lack of action taken by case management staff concerning Ms. Stinson's lack of compliance and her failure to participate with the reunification program prior to and following reunification.

- Documentation supports that the case manager was not making weekly visits, in accordance with the safety plan, following Jordan's reunification. While the issue was noted in a Rapid Safety Feedback conducted by the lead agency and addressed during a

supervisory review conducted by the case management agency, weekly visits continued to be a challenge due to either a lack of engagement on the part of the case manager or a lack of cooperation on the part of Ms. Stinson. Neither a multidisciplinary staffing was conducted nor was the matter brought before the court to determine the need for more aggressive services or possible modification of placement.

- As indicated above, Ms. Stinson missed three of her five scheduled visits, one of which was scheduled to occur on the day that reunification occurred. Following reunification, her lack of compliance continued as Ms. Stinson missed seven of 11 visits with the clinician and she was eventually unsuccessfully discharged from the reunification program. Again, a multidisciplinary staffing was not conducted, and the matter wasn't brought before the court to determine the need for more aggressive services or possible modification of placement.

FINDING C: When the new child abuse report was received in August 2018, alleging increased volatility between the parents, present danger was not appropriately assessed and identified. The child protective investigator's (CPI) assessment was based solely on the fact that the incident wasn't reported to the Florida Abuse Hotline when it initially occurred. The CPI failed to identify the active danger threats occurring within the household that were significant, immediate, and clearly observable. Given the circumstances, a modification of Jordan's placement should have been considered.

- Despite the time that elapsed between when the incident occurred and when it was reported to the hotline, there were still notable and active danger threats when the case was commenced given the on-going and escalating level of violence between the parents (as Mr. Belliveau was now openly threatening to kill the mother), the inability to control the situation, and the risk of harm posed to Jordan should Mr. Belliveau and Ms. Stinson engage in additional altercations.
- Mr. Belliveau had threatened to kill Ms. Stinson when law enforcement officials arrested him in July. Mr. Belliveau was a known gang member and a violent offender who had the means to carry out his threat. In addition, he had reportedly held a gun to her head during a previous incident, supporting his access to a weapon; and at the time of case commencement, he was no longer incarcerated and therefore had access to Ms. Stinson and Jordan. Lastly, Mr. Belliveau reported that he was the one who told Ms. Stinson not to open the door, resulting multiple law enforcement officials trying to convince her to cooperate, and further demonstrating the level of control he still possessed.

FINDING D: Despite the benefit of co-location, there was a noted lack of communication and collaboration between the Pinellas County Sheriff's Office CPID unit and Directions for Living case management staff in shared cases involving Jordan and his family, especially regarding the August 2018 child abuse investigation.

- While the department has policies and procedures in place that require a collaborative approach when there are shared cases between child protective investigators and case managers (CFOP 170-1, Chapter 11 "Investigations Involving an Ongoing Case," and CFOP 170-5, Chapter 7 "Inter-Agency Consultation and Teamwork"), the sheriff's offices are not required to adhere to the department's operating procedures as they operate under a legislative grant as opposed to a department-funded contract. However, section 39.301, Florida Statutes, titled "Initiation of Investigations" also requires a collaborative response "when a new investigator is assigned to investigate a second and subsequent report involving a child," as in the August 2018 investigation. Under those circumstances, "a multidisciplinary staffing shall be conducted which includes new and prior investigators,

their supervisors, and appropriate private providers in order to ensure that, to the extent possible, there is coordination among all parties."

- Prior to the receipt of the August investigation, case management, GAL, and legal staff were aware that a report would be forth-coming from the hotline, giving them an opportunity to initiate a coordinated response and assess for possible judicial action; however, this did not occur. Moreover, because the case manager did not respond when the report was received, the CPI had to rely on the on-call case manager and on-call attorney, neither of whom were familiar with the case.

FINDING E: In addition to the lack of communication and collaboration between frontline investigations and case management staff noted in Finding D, there was an absence of shared ownership between all entities involved throughout the life of Jordan's case which demonstrates a divided system of care. In addition, the lack of multidisciplinary team approach resulted in an inability to adequately address the identified concerns independent of one another.

- There was a lack of diligence in conducting multidisciplinary staffings at critical junctures of the case, which were especially important following reunification when Ms. Stinson was unsuccessfully discharged from the reunification program.
- As indicated earlier, neither the case management agency nor the attorney ensured that the court had accurate information when the mother provided false testimony.
- Regarding the court hearings, documentation in the case files, as well as the information shared with the team during interviews, often conflicted with what team members heard in audio recordings of the court hearings. This further emphasizes the need for on-going teaming and collaboration to ensure that all information was shared, and accurately so, as each entity came away from court hearings with a different interpretation of the court's recommendations.
- Information-sharing between Directions for Living clinical staff and Directions for Living case management staff was problematic and failed to note concerns with Ms. Stinson's non-compliance. Because system reviews across the state have often found record sharing to be problematic on the part of external mental health professionals, the team was surprised to note the same issue still existed when the mental health provider was internal with the case management organization. Both the case management organization and GAL were admonished in court for not obtaining the necessary records to support Ms. Stinson's lack of compliance with individual counseling and no one could offer an explanation as to why the provider from the same agency wasn't subpoenaed to testify before the court.
- Interviews supported a lack of interaction between the State Attorney, case management staff, and the foster parents prior to court hearings. The foster parents in this case felt uncomfortable stating their concerns to the court in front of the parents, with whom they were tasked to co-parent and, as a result, would report having no concerns when asked during court hearings. It should be noted, however, that the State Attorney's Office routinely provides foster parents with a Caregiver Input form along with a notice of the next hearing, so that written feedback can be provided in lieu of verbal testimony.
- On the surface, the local system of care appears to be cohesive and suggests a blended system of care. Below the surface, however, communication is lacking, resulting in a siloed approach to decision-making as opposed to a collaborative process with all equally responsible to ensure child safety and well-being. During the review, the team noted that interviews conducted with involved parties contradicted with and often placed blame on one another. This was further demonstrated when, instead of looking at the case from a holistic perspective, each entity focused on their own, isolated involvement within their specified boundaries.

FINDING F: The biopsychosocial assessments failed to consider the history and information provided by the parents and resulted in treatment plans that were ineffective to address behavioral change. Moreover, there was an over-reliance on the findings of the biopsychosocial assessments as to whether focused evaluations were warranted (e.g., substance abuse, mental health, domestic violence, etc.), despite the abundance of information to support such evaluations were necessary.

- [redacted], although Ms. Stinson specifically requested to have anger management, such services were not referred [redacted].
- Likewise, although Mr. Belliveau disclosed a history of violence [redacted], there was no recommended evaluation or specific treatment plan initiated beyond attending two additional counseling sessions to effectuate behavioral change.

Conclusion

Complex child welfare cases are difficult enough when high caseloads and continual staff turnover plague an agency. However, it is further impacted when those involved in the case (protective investigations, case management, clinical providers, legal, GAL and the judiciary) fail to work together to ensure the best decisions are being made on behalf of the child and their family.

This case highlights the fractured system of care in Circuit 6, Pinellas County, with each of the various parts of the system operating independently of one another, without regard or respect as to the role their part plays in the overall child welfare system. Until the pieces of the local child welfare system are made whole, decision-making will continue to be fragmented and based on isolated views of a multi-faceted situation.