Critical Incident Rapid Response Team

Laura and Jeffery Belval

Department of Children and Families
June 16, 2022,

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Laura and Jeffery Belval
Southern Region
Circuit 11
Miami-Dade County, Florida
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Executive Summary

At approximately 10 p.m., on April 12, 2022, local law enforcement was dispatched to, Odette Joassaint the mother's home, where they discovered Laura and Jeffrey, ages 5 and 3, deceased. As a result, the mother, Odette Joassaint, was arrested. At the time of the fatalities, the family was involved in an open investigation, however, only the mother and her [redacted], were involved with judicial case management. The cause of death for both children was ligature strangulation.

Due to the circumstances around the fatalities and the family's history, DCF Secretary Shevaun Harris deployed a Critical Incident Rapid Response Team (CIRRT) to Miami-Dade County. This report presents the team's findings, a summary of the family's child welfare history, the family's composition, and an analysis of Miami-Dade County's child welfare service providers. The team reviewed the family's prior interventions in the child welfare system to assess for any potential systemic matters within the local system of care.

The review team consisted of representatives from the DCF's Quality and Innovation Office, Child Protective Investigations in the Northeast Region, Substance Abuse and Mental Health from the Southern Region, Children's Legal Services (CLS) from the Northeast Region, Licensing Management, Case Management from the Northwest Region, and the Associate Statewide Child Protection Team (CPT) Medical Director.

The team reviewed case records involving all key case participants and conducted interviews with child welfare professionals involved in the recent interventions. The following agencies were interviewed during the review: DCF Child Protective Investigations (CPI) frontline and leadership staff, Family Resource Center (FRC) case manager supervisor, director, and leadership, placement staff, the Domestic Violence (DV) advocate, family finding intern, a member of the Transitional Trauma Therapy (TTT) Team, Child Welfare Integration and Support Team (CWIST) clinician and supervisor, and CLS.

This report represents the 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 system of care.

A summary of the team's findings is outlined in the following sections.

Summary of Findings:

Practice Assessment

- During the December 2021 investigation, the appropriate actions were taken to address [redacted] mental health needs. However, there was no ongoing assessment completed by the child welfare professionals to address the siblings, who were not part of the dependency action, to determine what, if any, additional service needs were present.

- Throughout the mother's history with the Department, she had a pattern of not cooperating with investigative staff. This contributed to a lack of thorough understanding of the mother's background and mental health history. In the December 2021 investigation, there were opportunities to collect additional information from a provider with whom the mother was known to cooperate.

- During the open investigation received on March 20, 2022, there was an opportunity to conduct a more in-depth analysis of the family to support the initial safety decision and/or to determine present danger. It should be noted that the investigation was open for 24 days at the time the fatalities occurred.

Organizational Assessment

- The child welfare professionals working with the family have a wealth of experience, knowledge, training, and available resources. In addition, the CPI, CPI Supervisor, and the initial Case Manager all had a thorough understanding of the Haitian culture.

- The region has a notification process immediately upon removal that quickly activates required responses from partner agencies.

Service Array

- There are substantial services within Miami-Dade County to support the needs of the various communities. In this case, the mother was known to have a distrust in government agencies and a lack of following through. Although service referrals were provided to the mother throughout her involvement with the child welfare system, there was no documented effort to link the mother with those services.

Case Participants

Name	Age at Time of Incident	Relationship
Laura Belval	5 Years	Deceased Victim
Jeffery Belval	3 Years	Deceased Victim
Odette Joassaint	41 Years	Mother
Frantzy Belval	45 Years	Father

Child Welfare Summary

At the time of Laura and Jeffery's death, April 12, 2022, the family was open to case management services with FRC.

Since 2017, the family has been involved in seven investigations, with allegations of domestic violence between the mother and the father of the deceased victims, potential sexual abuse of [redacted] substance misuse by the mother, concerns for [redacted] mental health and a single report with concerns for the mother's mental health.

In 2017, there was one investigation concerning an argument between the parents escalating with both becoming combative. Law enforcement determined the mother was the primary aggressor, and she was arrested. The report was closed with not substantiated findings of household violence threatens child maltreatment, and no services were offered.

In 2019, there were two investigations received. The first, in February, was received after the father was arrested for becoming violent with the mother and punching her several times in the head. The mother reported the incident was blown out of proportion, and the father reported he did not strike the mother. They both admitted to pushing each other, and no concerns were reported by a neighbor or paternal uncle. The investigation was closed with not substantiated findings of household violence threatens child maltreatment, while counseling was offered and declined.

The second report was received in October alleging concerns that [redacted] was exhibiting sexual behaviors and may be pregnant. [redacted] denied anyone touching her inappropriately or being pregnant. [redacted] was provided two pregnancy tests, and both were negative. The mother denied the child could have been sexually abused because she is always with her. During the investigation, the mother and children resided at Lotus House, a local woman's shelter. Lotus House was contacted and did not report any concerns for the family. The investigation was staffed with a CWIST clinician, who recommended and completed a referral to Banyan Health Services for [redacted]. The clinician recommended [redacted] receive a psychiatric evaluation, medical follow-up, and individual therapy. Due to the mother's history of DV, the clinician also recommended individual therapy for her. The report was closed with no indicators of sexual abuse. The mother and [redacted] never engaged in the referrals made by the CWIST clinician.

In 2020, there were two investigations received. [redacted] She described being resentful toward the Lotus House because she had to send [redacted] back to Haiti when the Lotus House wouldn't allow [redacted] to live there, [redacted] The mother was engaged in unknown services at the Lotus House. Three separate staff at the Lotus House were contacted and had no concerns. The investigation was staffed with a CWIST clinician, who recommended the mother receive a psychiatric re-evaluation, as the mother had one completed at the Lotus House. The clinician also recommended the mother be referred to Citrus Health Network prevention services for follow-up to ensure the mother complied with services. The investigation was closed with no indicators of inadequate supervision, the mother was referred to Healthy Start and Family Services, and the mother declined those services.

The second investigation was received in October after [redacted] was hospitalized [redacted]. The mother advised she felt the medications were not helping [redacted], they were hurting her [redacted] The mother eventually allowed treatment for [redacted], as recommended. [redacted]; the CPT recommended no findings for medical neglect. Mr. Belval advised he has his two children on the weekends and has never observed concerning marks or bruises and had no concerns for the mother. The investigation was closed with no indicators of medical neglect, and the mother was referred to Family Services to assist with engagement and understanding of [redacted]. The mother did not engage in the program.

In 2021, there were two investigations received. The first investigation in July alleged the mother was providing [redacted] with alcohol. The mother wasn't cooperative and refused to be interviewed, as well as [redacted]. The law enforcement report reflected the mother and [redacted] denied the allegations and the investigation was unfounded. Mr. Belval was contacted and reported his concern for [redacted]. He was afraid [redacted] may harm his two children. The investigation was closed with no indicators of substance misuse. There was no documentation to show if services were referred for the family.

The second investigation was received in December after [redacted] was admitted to the hospital [redacted], and the mother refused to allow the hospital to provide treatment and medication. [redacted] was in the hospital for approximately two months and hospital staff petitioned the courts for an order for treatment. The mother continued to disregard the need for treatment and refused any assistance or services.

On February 15, 2022, [redacted] was determined to be unsafe, sheltered from her mother's care, and placed in a residential licensed home. The two younger children were determined to be safe and remained in the legal custody of both parents, with their father, Mr. Belval, playing an active part of their lives. On February 19, 2022, the investigation was closed with verified findings of medical neglect on [redacted]

Three days later, on February 22, 2022, the mother and [redacted] were transferred to judicial case management services with Citrus Family Care Network. [redacted] was referred to Agency for Persons with Disabilities (APD) on February 24, 2022. [redacted] Referrals were completed for the mother on March 7, 2022, for individual therapy, family therapy, and a psychological evaluation.

[redacted]

On March 20, 2022, an investigation was received; it alleged the mother and father engaged in an argument in front of the children. It escalated into the father striking the mother four times.

The CPI made attempts at the daycare, the mother's residence, and the father's residence, to locate the three-year-old and five-year-old. They were eventually seen at the father's home on April 2, 2022. The father denied the allegations and reported that the mother was a "liar." He further advised he had paperwork and would be filing for custody of the children in family court.

Two collateral contacts were completed—one with the neighbor and another with the director at the children's daycare. The neighbor advised the altercation was observed and denied the

father struck the mother. The neighbor also stated the parents argue often and have an on-again off-again relationship. The daycare director advised that there were no concerns for the children with the parents. The children were well-groomed and never observed with unexplained injuries or bruises. In addition, the mother was never observed to be aggressive with daycare staff. The mother refused to be interviewed and advised the CPI to review the police report for her statements.

During the March 21st court hearing, the mother was found in default, because she did not attend the court hearing. This automatic default, for not attending, resulted in a consent plea, and she was court ordered a case plan.

At the time of the Belval children's deaths on April 12, 2022, the mother had not participated in services or attended any court hearings.

System of Care Review

This review is designed to provide an assessment of the child welfare system's interactions with the Belval children and to identify matters that may have influenced the system's response and decision making.

Practice Assessment

PURPOSE: This practice assessment examines whether the child welfare professionals' actions and decision-making regarding the family were consistent with the Department's policies and protocols.

FINDING A: During the December 2021 investigation, the appropriate actions were taken to address [redacted] needs. However, there was no ongoing assessment completed by the child welfare professionals, to address the siblings, who were not part of the dependency action, to determine what, if any, additional service needs were present.

Throughout the family's involvement with the department, the investigative staff worked with CWIST clinicians. CWIST was created in the Southern region to integrate behavioral health within the child welfare system. The clinicians are collocated with the CPIs and provide direction around substance misuse, behavioral health, and mental health. The CPIs can request either a consult or a joint response for a brief assessment. This process was introduced to ensure CPIs gather sufficient information about behavioral health conditions, mental health functioning, and substance use. The clinicians were contacted in the 2019, 2020, and 2021 investigations.

In the December 2021 investigation, there were several collaborative discussions around [redacted] needs and what her treatment plan should entail. The investigative staff did an excellent job of working directly with the [redacted] staff to ensure there was a clear understanding of what medications [redacted] needed to keep her stable. These in-depth conversations and collaborative discussions provided the knowledge and understanding of [redacted] needs. The investigation revealed that the mother was unwilling to provide [redacted] with her medications, resulting in the Department taking dependency action.

The December 2021 investigation documented an in-depth assessment of [redacted] and what actions were needed from the department to keep her safe. While the

appropriate actions were taken to ensure [redacted] was safe, there was a lack of continued assessment of the siblings who also resided in the home with the mother. CFOP 170-1 Chapter 9 provides guidance around the continued assessment of children who reside in the home of a parent receiving ongoing case management services. The operating procedure states, in part:

> "The child welfare professional must complete an assessment in any of the following circumstances:
>
> b. A child will be residing in the home of the parent/significant caregiver receiving ongoing case management services. "Resides" means that the child will live in a home on a permanent basis including any timesharing custody agreements."

Even though the siblings were not part of the dependency action, there should have been an ongoing assessment of their needs, wellbeing, and safety. There was no documentation to indicate the siblings were observed or assessed during the short time they were open to case management.

FINDING B: Throughout the mother's history with the department, she had a pattern of not cooperating with investigative staff. This contributed to a lack of thorough understanding of the mother's background and mental health history. There were opportunities in the February 2020 investigation to collect additional information from a provider with whom the mother was known to cooperate.

During the Department's involvement with the family, the mother was reluctant to communicate with CPI staff. She often refused communication, stating she didn't trust the government. However, once she observed the father communicating and interacting with the CPI, she became more open and willing to provide information, although still guarded.

While there were other opportunities to gather additional information from various sources, these activities were not completed.

For example, although the Lotus House was contacted to inquire about the mother's behaviors while residing at the shelter, there was no documentation showing specific questions were asked about the services provided (e.g., psychiatric evaluation and case management services). Gathering more information about the services may have shed light on the mother's mental health, and how it had the potential to impact her ability to parent and protect her children.

During the same investigation in 2020, CWIST recommended that the mother get a psychiatric re-evaluation and individual therapy for her DV history. There was no documentation that a discussion occurred with the mother about these recommendations. The clinician also made recommendations for [redacted] to get a psychiatric evaluation and individual therapy. It is unknown what the outcomes were around these recommended services and assessments.

Another opportunity to gather information was from the staff at [redacted] school, if contact had been made. At the time, [redacted] was participating in an Individualized Education Plan (IEP)

which allows her teachers, her mother, school administrators, and related service personnel to work collaboratively on improving [redacted] educational needs. The school could have provided an understanding of how involved the mother was in the development of [redacted] plan, how she communicated with the school, and to address any additional concerns. Additionally, this may have provided another avenue to engage the mother and assess for any additional services.

FINDING C: During the open investigation received on March 20, 2022, there was an opportunity to conduct a more in-depth analysis of the family to support the initial safety decision and/or to determine present danger. It should be noted that the investigation was open for 24 days at the time the fatalities occurred.

There was documentation to support pertinent information was assessed to inform the initial safety determination; however, the totality of the history and current allegations were not sufficiently analyzed together. At the time of commencement on March 20, 2022, the DV incident was the third DCF documented altercation between the mother and father, Mr. Belval. On March 21, 2022, CPI staff attempted a visit to the mother's home; however, the mother and children were not home. CPI staff contacted a neighbor who confirmed the mother and father did engage in an argument in front of the children. The neighbor described both parents being aggressive, with the mother pushing the father against the car. The neighbor went on to say the parents had a pattern of screaming at each other, separating, and then the father returning to the mother's home weeks later.

The following day, the CPI attempted to locate the children at the daycare. Although the children were not present, the CPI spoke with the daycare director, who didn't have any concerns for the children's wellbeing with either parent. Telephone contact was made with the father the same day and he did not present any concerns for the children. The CPI continued to make several failed attempts to interview and see the children, the mother, and the father.

The children were eventually observed in the father's home on April 2, 2022. The limited documentation indicates they presented with no injuries and appeared to be bonded with the father. While the daycare director and the father did not describe any concerns for the children, this presented an opportunity to gather more information about the mother's mental health, and her ability to care for the children and protect them. The parent's volatile relationship, coupled with the father's arrest in 2012 for aggravated battery on a pregnant woman, the mother's unclear mental health, and [redacted] removal warranted a more in-depth analysis of the family dynamics.

Organizational Assessment

PURPOSE: This section examines the level of staffing, experience, caseload, training, and performance as potential factors in the management of this case.

FINDING A: The child welfare professionals working with the family have a wealth of experience, knowledge, training, and available resources. In addition, the CPI, CPI Supervisor, and the initial Case Manager all had a thorough understanding of the Haitian culture.

The same CPI was assigned to the December 2021 and the March 2022 investigations. The CPI has 17 years of experience and holds a master's degree in human services and child

protection. The CPI had a total of 34 active investigations when case # 2022-085556 was received. During the department's involvement with the family, the CPI's caseload was above the recommended average. The CPIS has a total of eight years of experience and a degree in political science. At the time of this review, the CPIS had a single case on his caseload, which he inherited when another CPI left the department. The staff reported that a supervisor having a caseload isn't a typical occurrence. Both the CPI and CPIS have experience and knowledge; however, they reported the caseload and shortage of staff caused additional strain on their daily duties. The staff reported having to rush through initial and follow-up supervisory staffings to ensure the CPI had time to complete all necessary fieldwork. The CPI staff spoke highly of leadership, indicating they felt comfortable communicating any barriers and brainstorming ideas with them.

A few weeks after the family transitioned to FRC, the CM ended her employment with FRC. As a result, the case was assigned to the CMS. The CMS has a caseload of seven families and 16 years of experience. FRC recognized the strain and implemented numerous supports to assist staff with caseloads and timely case actions. A few of those supports include transportation staff, a clinical team with a therapist, one case management specialist (per unit), a court liaison, and a quality parent initiative liaison. The CM staff spoke highly of the support FRC has implemented.

The shelter attorney has been with CLS for three years, while the CLS supervising attorney has worked with CLS since 2016. The shelter attorney works with the family until the arraignment, and then the family is transferred to the correct division. The CLS divisions are assigned based on the judge. The supervising attorney attributes her caseload of 60 to vacancies. There should be three to four attorneys; however, there are currently only two.

Both the CM and CPI were fluent in Creole and had a high level of understanding of Haitian culture. Having a shared language is crucial in enhancing communication and collaboration. This shared experience increased the possibility of the mother feeling more comfortable with the staff. Understanding the mother's cultural perspectives is knowing her beliefs, values, and priorities. The staff needs to know what is important to the mother, as it impacts what she wants for her children. The staff was able to recognize and affirm these beliefs and values with the mother.

FINDING B: The region has a notification process immediately upon removal that quickly activates required responses from partnered agencies

The Southern region created a notification process that immediately notifies all pertinent parties that a Decision Support Team (DST) call is needed when the removal of a child is determined to be necessary. Upon the decision that removal is necessary to maintain a child's safety, the CPI Program Administrator (PA) contacts the shelter attorney to provide a summary of the case and any additional documentation. The shelter attorney will review the information provided within specified timeframes: 15 minutes for cases with present danger and 24 hours for cases with impending danger. The participants included in the email group are all notified about the DST call immediately. This notification process allows the agencies to get the removal information simultaneously and timely. During the DST call, other agencies are gathering information and beginning their assigned activities. Citrus Family Care Network and the case management organization use this time to gather information on the family, prior to case transfer.

Family finders' staff utilize the DST call to begin the process of identifying and locating potential relatives for placement. To save time, placement staff begin identifying appropriate licensed care for the child(ren) in the event a relative is unable to be located.

While CLS and the CPI are discussing the child's history, the TTT team takes notes to ensure they have a solid understanding of what is needed from a therapeutic standpoint. The TTT team gathers information related to the child's history and begins a full trauma assessment. The TTT team starts the assessment during the DST call because the trained trauma therapists meet the CPI at the home during the removal. The TTT team also helps by transporting the child to the new placement. After the child is settled in the new placement, the TTT team completes a comfort call between the caregiver and the parents. Research shows that reunification and permanency are more successful when positive co-parenting occurs. The comfort calls are used to build a relationship between the caregiver, the birth parent, and the child welfare professional, while hopefully reducing the trauma, encouraging co-parenting, and achieving successful outcomes for the child.

In addition to the above staff that are on the DST call, the Children's Reception Intake Base (CRIB) program staff attend the call. CRIB was designed to provide the child with a therapeutic, safe, child-friendly environment until relatives and/or a more permanent placement could be identified. Their attendance assists with gathering child information in preparation if their service is needed.

Having this DST call ensures the CPI shares the information once and promotes a smooth removal. The CPI can then focus on the child's wellbeing during the removal versus other important activities.

Service Intervention/Array

PURPOSE: This section assesses the inventory of services within the child welfare system of care.

FINDING A: There are substantial services within Miami-Dade County to support the needs in the various communities. In this case, the mother was known to have a distrust in government agencies and a lack in following through with referred services. Although numerous service referrals were provided to the mother throughout her involvement with the child welfare system, there was no documented effort to link the mother with those services.

Miami-Dade County has several programs available to meet the family's needs. Citrus Family Care Network, the community-based care lead agency in Miami-Dade County, subcontracts with four Full Case Management Agencies (FCMAs). The FCMAs provide protective supervision and the coordination of services for children in the county. The subcontracted agency working with this family was FRC.

FRC provides Full Case Management (FCM) which includes, in part, prevention/treatment services, mental health counseling, psychiatric consultations, case plan management, parent education, child parent psychotherapy, and adoption services.

While the Department was involved with the family, they were referred to several community services. A community service refers to a service referred by the Department, but not

necessarily paid for or monitored by the department. Between 2017 and 2019, the mother and child were referred to counseling on two separate occasions; however, the mother didn't engage in these referrals. At the end of the 2020 investigation, the mother was also referred for services through Healthy Families, a voluntary and nationally accredited program that assists parents in learning how to recognize and respond to their child's developmental needs, using positive discipline techniques, while coping with the day-to-day stresses of parenting. There was no documentation signifying if the mother did or didn't follow through with the referral.

Although the mother had a pattern of not complying with any services offered by the Department, she did, however, participate in services that were provided through Lotus House. Lotus House is the largest shelter, in the United States, for women and children. It provides not only shelter, but also resources and support services to the women and children in Miami-Dade County. The services offered at Lotus House include, in part, shelter, medical and mental health care, parenting education, counseling, parent and/or child therapy, and job training. There was no documentation to support that Lotus House was contacted to ascertain the type of services the mother was provided and her level of engagement.

While residing at Lotus House, the mother was told [redacted] could no longer reside there due to her behaviors. As a result, the mother bought a plane ticket and flew [redacted] to Haiti, while she and the other two children continued to reside at Lotus House. At an unknown time, [redacted] returned to the United States and moved into a home with her mother and her siblings. Child welfare professionals didn't contact the shelter to determine if there was an option for services while the mother no longer lived there.

Given the parents' history with DV, a consultation with the co-located DV advocate was warranted to determine what, if any, DV-related services should be referred. The Safe Space foundation provides a DV advocate, who is co-located with the CPI staff. This co-location allows staff to have face-to-face collaborative discussions around each investigation, with DV allegations. The organization focuses on empowering women with a 9-week program that teaches, in part, personal and interpersonal skills, provides budget education and helps the women build and maintain healthy relationships. It also teaches women how to effectively communicate while being assertive. The staff also participate in weekly meetings, which contribute to a strong relationship between the Safe Space Foundation and staff.

Throughout this family's involvement with the Department, there was a disconnect between linking the family with services versus referring them to services. The family was referred to Village South, who provide in-home, family services, and family support services. Depending on the service, a specialist may work with the family for 30 to 60 days.