



**Tennessee Department of Children's Services  
Tennessee Child Abuse Hotline Summary**

**Intake**

Intake ID: [REDACTED]  
 Intake Taken By: [REDACTED] Intake Date/Time: 05/19/2015 11:45 AM [REDACTED]  
 Track Assigned: Investigation Priority Assigned: 1  
 Screened By: [REDACTED]  
 Date Screened: 05/19/2015

**Investigation**

Investigation ID: [REDACTED]  
 First County/Region: [REDACTED]  
 Date/Time Assigned : 05/19/2015 03:23 PM  
 First Team Leader Assigned: [REDACTED] Date/Time 05/19/2015 12:00 AM  
 First Case Manager [REDACTED] Date/Time 05/19/2015 12:00 AM

**Allegations**

Alleged Victim	Age	Allegation	Severe ?	Alleged Perpetrator	Relationship to Alleged Victim
[REDACTED]	6 Mos	Neglect Death	Yes	[REDACTED]	Birth Father
[REDACTED]	6 Mos	Neglect Death	Yes	[REDACTED]	Birth Mother

**Referent(s)**

Referent Name: [REDACTED] Role to Alleged Victim(s): [REDACTED]

Referent Address: [REDACTED]

Referent Phone Number: [REDACTED]

Type of Contact: I-3 Phone

Notification: None

Narrative: \*\*\*THIS CHILD IS NOT IN CUSTODY\*\*\*\*\*

TFACTS:

Family Case IDs: [REDACTED]

Open Court Custody/FSS/FCIP: No  
 Prior INV/ASMT of Abuse/Neglect: 4  
 Prior INV/ASMT of Abuse/Neglect in the last three years: Yes  
 Screen Outs: 0

Open:  
 Investigation [REDACTED] DEI;DEC/Non-Classified/05.11.2015 [REDACTED] (CM) and [REDACTED]  
 (Supervisor)

**Tennessee Department of Children's Services  
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Substantiated:

Investigation [REDACTED]/DEC [REDACTED] Substantiated/10.10.2011

Assessment [REDACTED]/DEC [REDACTED] and [REDACTED] Services Recommended and Accepted/04.20.2015

Investigation [REDACTED] PHA [REDACTED] Unsubstantiated/10.01.2008

Investigation [REDACTED] LOS; DEC [REDACTED] and [REDACTED] 01.24.2005

DUPLICATE REFERRAL: No

County: [REDACTED]

Notification: None

School/ Daycare: None

Native American Descent: None

Directions: N/A

Reporter's name/relationship: [REDACTED]

This child is not in custody.

Reporter states:

[REDACTED] (11 days) was in the care of his parents, [REDACTED] and [REDACTED]. [REDACTED] is currently deceased. [REDACTED] passed Sunday, May 17, 2015. [REDACTED] states that [REDACTED] passed away at [REDACTED] Hospital Association in [REDACTED] Tennessee. [REDACTED] states that [REDACTED] was taken to the hospital due to concerns of him breathing abnormally. [REDACTED] states that this was around 4:00 a.m. Referent believes that [REDACTED] and [REDACTED] transported [REDACTED] to the hospital. [REDACTED] states that they took him to the hospital. [REDACTED] indicated that [REDACTED] was still breathing while en route to the hospital. [REDACTED] states that medical personnel worked on [REDACTED] for two hours, but that they were "unable to fix it." [REDACTED] states that a tube was placed inside of [REDACTED] to help him breathe, and that formula came out. It is unclear if formula came out of the tube or out of [REDACTED] mouth. [REDACTED] states that Medical Personnel made statements indicating that something could have been wrong with [REDACTED] throat, and it may not have developed properly. [REDACTED] states that the hospital is conducting an autopsy. The county Detective, [REDACTED] has been contacted, and he indicated that he was not made aware of the incident. Mr. [REDACTED] was contacted today. This is possibly due to [REDACTED] passing away at the hospital.

[REDACTED] (Maternal Grandmother) and [REDACTED] (Paramour) reside in the home; however, the only adult in the home that has been contacted at this time is [REDACTED]. Referent states that [REDACTED] was contacted by the current CPS Investigator, [REDACTED]. Ms. [REDACTED] is currently involved with the family due to allegations of Drug Exposed Infant and Drug Exposed Child involving [REDACTED] and [REDACTED]. [REDACTED] is [REDACTED] other child. [REDACTED] is currently in the care of Paternal Grandmother, [REDACTED] since 2013. [REDACTED] does have another grandchild, [REDACTED] (4) that lives in the home. [REDACTED] is no [REDACTED] child. [REDACTED] and [REDACTED] Father is [REDACTED]. [REDACTED] has supervised visits with [REDACTED] and [REDACTED] on the weekends. [REDACTED] has unsupervised with [REDACTED] every other weekend. It is unknown where [REDACTED] and [REDACTED] are at this time. There are no other concerns of abuse at this time. [REDACTED] has a history of incarceration to drugs in the past (2013). [REDACTED] and [REDACTED] have a history of using drugs. [REDACTED] and [REDACTED] are currently using non-prescribed Suboxone. There was a meconium test completed when [REDACTED] was born. Those results are still pending.

The current Case ID: [REDACTED]

Special Needs or Disabilities: No

Child's current location/is the child safe at this time [REDACTED] is deceased. [REDACTED] is with [REDACTED]



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Perpetrator's location at this time: Unknown

Any other safety concerns for the child (Ren) or worker who may respond: No

Is there domestic violence in the home? No

Per SDM: Investigative Track, P1

██████████ @ 2:47 p.m. on 5/17/15

\*\*A copy of this referral was emailed to the ██████████ Regional Administrator, Ms. ██████████, and the ██████████ email notification group. \*\*



**Tennessee Department of Children's Services  
Tennessee Child Abuse Hotline Summary**

**Participant(s)**

**Name:** [REDACTED]

Gender: Female

Date of Birth:

Participant ID: [REDACTED]

SSN:

Race: White

Age: 4 Yrs (Est)

Address:

Deceased Date:

School/ ChildCare Comments:

Alleged Perpetrator: No

DCS Foster Child: No

Contact:

Contact Type:

Contact Comments:

**External History Search Results:**

**DCS History Search Results:**

**DCS Intake Search Results:**



**Tennessee Department of Children's Services  
Tennessee Child Abuse Hotline Summary**

**Name:** [REDACTED]

Gender: Male

Date of Birth: [REDACTED]

Participant ID: [REDACTED]

SSN: [REDACTED] Race: White Age: 26 Yrs

Address:

Deceased Date:

School/ ChildCare Comments:

Alleged Perpetrator: No

DCS Foster Child: No

Contact:

Contact Type:

Contact Comments:

**External History Search Results:**

**DCS History Search Results:**

**DCS Intake Search Results:**



**Tennessee Department of Children's Services  
Tennessee Child Abuse Hotline Summary**

Name: [REDACTED]

Gender: Female

Date of Birth: [REDACTED]

Participant ID: [REDACTED]

SSN:

Race: White

Age: 9 Yrs

Address: [REDACTED]

Deceased Date:

School/ ChildCare Comments:

Alleged Perpetrator: No

DCS Foster Child: No

Contact: [REDACTED]

Contact Type: RELATIVE

Contact Comments:

**External History Search Results:**

**DCS History Search Results:**

**DCS Intake Search Results:**



**Tennessee Department of Children's Services  
Tennessee Child Abuse Hotline Summary**

**Name:** [REDACTED]

Gender: Female

Date of Birth:

Participant ID: [REDACTED]

SSN:

Race:

Age:

Address:

Deceased Date:

School/ ChildCare Comments:

Alleged Perpetrator: No

DCS Foster Child: No

Contact:

Contact Type:

Contact Comments:

**External History Search Results:**

**DCS History Search Results:**

**DCS Intake Search Results:**



**Tennessee Department of Children's Services  
Tennessee Child Abuse Hotline Summary**

**Name:** [REDACTED]

Gender: Male

Date of Birth:

Participant ID: [REDACTED]

SSN:

Race: Unable to

Age:

Address:

Deceased Date:

School/ ChildCare Comments:

Alleged Perpetrator: No

DCS Foster Child: No

Contact:

Contact Type:

Contact Comments:

**External History Search Results:**

**DCS History Search Results:**

**DCS Intake Search Results:**



**Tennessee Department of Children's Services  
Tennessee Child Abuse Hotline Summary**

**Name:** [REDACTED]

Gender: Female

Date of Birth:

Participant ID: [REDACTED]

SSN:

Race: Unable to

Age:

Address:

Deceased Date:

School/ ChildCare Comments:

Alleged Perpetrator: No

DCS Foster Child: No

Contact:

Contact Type:

Contact Comments:

**External History Search Results:**

**DCS History Search Results:**

**DCS Intake Search Results:**



**Tennessee Department of Children's Services  
Tennessee Child Abuse Hotline Summary**

Name: [REDACTED]

Gender: Male

Date of Birth: [REDACTED]

Participant ID: [REDACTED]

SSN: [REDACTED] Race: White Age: 30 Yrs

Address:

Deceased Date:

School/ ChildCare Comments:

Alleged Perpetrator: Yes

DCS Foster Child: No

Contact:

Contact Type:

Contact Comments:

**External History Search Results:**

**DCS History Search Results:**

**DCS Intake Search Results:**



**Tennessee Department of Children's Services  
Tennessee Child Abuse Hotline Summary**

**Name:** [REDACTED]

**Gender:** Male

**Date of Birth:** [REDACTED]

**Participant ID:** [REDACTED]

**SSN:**

**Race:** White

**Age:** 6 Mos

**Address:** [REDACTED]

**Deceased Date:**

**School/ ChildCare Comments:**

**Alleged Perpetrator:** No

**DCS Foster Child:** No

**Contact:** [REDACTED]

**Contact Type:** CELL

**Contact Comments:**

**External History Search Results:**

**DCS History Search Results:**

**DCS Intake Search Results:**



**Tennessee Department of Children's Services  
Tennessee Child Abuse Hotline Summary**

**Name:** [REDACTED]

Gender: Female

Date of Birth: [REDACTED]

Participant ID: [REDACTED]

SSN: [REDACTED] Race: White Age: 24 Yrs

Address:

Deceased Date:

School/ ChildCare Comments:

Alleged Perpetrator: Yes

DCS Foster Child: No

Contact:

Contact Type:

Contact Comments:

**External History Search Results:**

**DCS History Search Results:**

**DCS Intake Search Results:**



**Tennessee Department of Children's Services  
Child Protective Service Investigation Summary  
and Classification Decision of Child Abuse/Neglect Referral**

**A. Investigation**

Case Name: [REDACTED]

Investigation ID: [REDACTED]

Referral Date: 05/19/2015

Assignment Date: 05/19/2015

Street Address: [REDACTED]

City/State/Zip: [REDACTED]

**B. Allegation**

#	Children's Name	DOB	Specific Allegation for Each Child	Alleged Perpetrator's Name	DOB	Classification	Severe Abuse	Classified By
		SSN			SSN			
1	[REDACTED]	[REDACTED]	Neglect Death	[REDACTED]	[REDACTED]	Allegation Unsubstantiated / Perpetrator Unsubstantiated	Yes	[REDACTED]
		[REDACTED]			[REDACTED]			09/09/2015
2	[REDACTED]	[REDACTED]	Neglect Death	[REDACTED]	[REDACTED]	Allegation Unsubstantiated / Perpetrator Unsubstantiated	Yes	[REDACTED]
		[REDACTED]			[REDACTED]			09/09/2015

**C. Disposition Decision**

Disposition Decision: Refer for Other Services and Close

Comments: Based upon the information and evidence gathered during the course of the investigation, there is not a preponderance of evidence to substantiate the allegation. The infant's autopsy showed that he died of acute mitral valve insufficiency due to impaired left ventricular papillary muscle function due to lymphocytic myocarditis. The autopsy revealed a viral infection of the heart muscle associated with a large area of myocyte necrosis within one of the papillary muscles of the left ventricle. This large area of necrosis caused the papillary muscle to improperly function leading to acute mitral valve insufficiency, which explains [REDACTED] initial symptoms and rapid progression to respiratory failure. The infant's death could not have been prevented [REDACTED] County Child Protective Investigative Team was in agreement with the classification.

**D. Case Workers**

Case Worker: [REDACTED]

Date: 09/09/2015

Team Leader: [REDACTED]

Date: 09/09/2015

**E. Investigation Summary**

**Instruction: Condense the finding rationale for each allegation relative to the child victim(s). Be sure to identify the facts that provided for the classification decision.**

**Summarize the key points and dates of the child or children's statements and/or the observation of the child or children's physical state or home environment:**

Infant was deceased at the time of the referral and initiation of this investigation.



**Tennessee Department of Children's Services**  
**Child Protective Service Investigation Summary**  
**and Classification Decision of Child Abuse/Neglect Referral**

Case Name : [REDACTED]

Investigation ID: [REDACTED]

**Summarize professional, medical or psychological findings or opinions: What is the collateral's oral or written finding/opinion of the incident(s)/allegation(s)?**

Maternal grandmother [REDACTED] maternal great-grandmother [REDACTED] and household member [REDACTED] reported [REDACTED] behaved normally and the same from the time he was in the hospital until Saturday (5/16/15) night. They denied any changes in behavior, feeding, sleeping, bowel movements, or urine output. It was reported the formula had recently changed on Saturday from Similac Sensitive to Similac Advance. The family reported no concerns about the care of the child or about the parents.

[REDACTED] was discharged from [REDACTED] Medical Center on 5/13/15. He was seen by his pediatrician, Dr. [REDACTED] on 5/15/15 for a new well child check. There were no feeding problems reported and the mother brought a paper log of feedings. His stool was reported to be normal consistency. He was voiding urine well. His breathing pattern was normal, no apnea, and cough denied. There were no concerns of abuse or neglect. He appeared alert and well nourished. He was seen on 5/16/15 for circumcision. There were no concerns noted and he tolerated the procedure well. Dr. [REDACTED] completed a progress note regarding the incidents and death of [REDACTED] on 05/17/2015. She was contacted at 6:14 AM by the mother who said the infant was "breathing funny" and was waxy and white. Dr. [REDACTED] directed the mother to the closest emergency room and Dr. [REDACTED] arrived by 7:00 AM. She observed a baby that was very pale with supportive breathing and bagging in process. The note then went through a timeline of medical procedures that were completed on the infant. Medical personnel felt there was some foreign body appearing or foreign tube that appeared in the back of the posterior pharynx competing the attempts at intubation. They were not able to pull it out or to figure out what it was exactly that this object was. After coding the infant for 2 ¼ hours without any success and Dr. [REDACTED] noted the infant to have no corneal reflexes, no heartbeat, no breathing spontaneously, no response to painful stimulus, he was pronounced at 9:15 AM.

The provisional autopsy report was received on 5/20/15. The cause of death was listed as pending. The presence of an endotracheal tube in oropharynx, esophagus, and stomach was noted. The medical examiner's office at [REDACTED] Hospital Association reported the object found was not medical and they did not know what it was. They said the object was not from their facility. The Forensic Center reported the object found in the child's throat was an endotracheal tube. They did not know where the tube came from. Dr. [REDACTED] reported the tube was located in the child's esophagus and into the stomach. He reported there was milk/formula below the tube, above the tube, and clogged in the tube. He reported the tube found in the infant could be a contributing factor in the infant's death. He did not believe the withdrawal symptoms were a contributing factor in the infant's distress or death as signs of withdrawal usually arose within approximately 24 hours.

[REDACTED] social worker at [REDACTED] Medical Center, denied the child had any medical issues while he was in the hospital. She denied he was intubated at any time during his stay in the hospital. She denied there had been any tubes placed in the infant or that he was intubated.

The autopsy report was completed on 08/19/2015. According to the autopsy, [REDACTED] died of acute mitral valve insufficiency due to impaired left ventricular papillary muscle function due to lymphocytic myocarditis. An autopsy revealed a viral infection of the heart muscle associated with a large area of myocyte necrosis within one of the papillary muscles of the left ventricle. This large area of necrosis caused the papillary muscle to improperly function leading to acute mitral valve insufficiency, which explains [REDACTED] initial symptoms and rapid progression to respiratory failure. [REDACTED] Child Safety Nurse, confirmed that the child's death could not have been prevented.

**Summarize alleged perpetrator's statement or admission: What is the perpetrator's explanation of the incident(s)/allegation(s)?**

[REDACTED] reported she stopped breastfeeding at [REDACTED] Medical Center. They initially gave [REDACTED] Similac Advance. He was fussy and was then switched to Similac Sensitive. He was taking small pre-made bottles. The hospital could not provide Similac Sensitive to take home but she was able to take the remaining bottles from the hospital room. The hospital sent a large bottle of Similac Advance home. Mother denied any changes in [REDACTED]



**Tennessee Department of Children's Services**  
**Child Protective Service Investigation Summary**  
**and Classification Decision of Child Abuse/Neglect Referral**

Case Name : ██████████

Investigation ID: ██████████

behaviors, feeding, bowel movements, etc. They had been monitoring him for withdrawal symptoms such as tremors, shaking, and fussiness as advised by the hospital. He may have spit up twice while he was at home and it was normal spit up. He was typically given two ounces of formula every three to four hours. On Saturday night the 16th, mother, father, and infant slept in the same bed. ██████████ was reportedly wearing a diaper, socks, and a complete onsie with feet. He was swaddled. ██████████ liked to be swaddled tightly and she had the nurses at the hospital instruct her on how to swaddle him. She denied they used any blankets on the bed that night. She explained the father was lying on the left side of the bed, ██████████ was in the right corner, and she was lying perpendicular at the end of the bed. ██████████ woke up around 2am on the morning of Sunday the 17th. She had run out of the Similac Sensitive and had to make a bottle with the Similac Advance. He took about two ounces and went back to sleep. He woke up again around 4am. She did not notice any changes in ██████████ and had no concerns at that time. She made him another bottle and he took about one ounce. He usually drank the whole bottle but was not too worried as he had a full two ounces only two hours earlier. He fell back asleep. She woke up around 6am. When she woke up, the father was awake and had his arm stretched to touch the baby. She began to make him a bottle but realized he was making an odd sound. She described the sound as a grunting type sound or "uh, uh, uh." It was like he could not catch his breath. His eyes were reacting but not his body. She took him to her grandmother. They changed the child's diaper. She noticed the child's skin was white. They contacted the child's primary care physician and were advised to take the child to the nearest emergency room. She, the father, and infant arrived at ██████████ Hospital approximately 20 minutes later. The mother said she was not exactly sure what took place at the hospital. She saw a "thing" over his face to make him breath. She said later one of the nurses said they were trying to put a tube down his throat. She said medical personnel told her ██████████ was just having some trouble breathing. She said the doctor asked her if anyone put something in his mouth. She said the doctor said it was like something was blocking his airway. She was told when the tube was put in, formula came up. ██████████ said the only things that had been placed in the infant's mouth were his passie and bottle.

██████████ also denied observing any changes in the infant's behaviors, eating, sleeping, bowel movements, etc. He reported they went to bed on Saturday night the 16th around 10:30 or 11pm. He was not sure exactly what time ██████████ got up; it was 12:30, 1, or 2am. ██████████ fixed a bottle. Both of them participated in feeding at that time. He was not sure when ██████████ awoke next as he did not wake up at that time. When he woke up that morning, ██████████ was "breathing funny." It was like ██████████ was in pain. He said the sound was like a half cry or he was short of breath. They took ██████████ to the emergency room. He was intially told by a nurse that ██████████ was breathing okay. A couple of hours later, he died. When questioned about co-sleeping with the infant, he explained he and the mother were on opposite sides of the bed and ██████████ slept on his back in between them. He said there was approximately a foot and a half of space between ██████████ and each of them.

**Summarize witnesses' descriptions of what they saw and what they believe indicates child abuse/neglect:**

██████████ was born on ██████████ at The ██████████ Medical Center (██████████ Medical Center) in ██████████ to parents ██████████ and ██████████. He was observed in the hospital for signs of withdrawal due to the mother taking non-prescribed Suboxone while pregnant but was ultimately released without complications. It was reported that ██████████ was doing well after discharge. He saw his pediatrician on 05/15/2015 for a new well child visit and again on 05/16/2015 for his circumcision.

Early in the morning on Sunday 05/17/2015, the parents became concerned because the infant was "breathing funny." The child's pediatrician was contacted and the family was advised to go to the emergency room. The mother, father, and infant arrived at ██████████ Hospital Emergency Room at 6:41AM. Hospital personnel attempted intubation several times. The infant was pronounced deceased at 9:15 AM.

The Department was not made aware of the infant's death until 05/19/2015.

At the time of the infant's death and new referral, there was an open investigation ██████████ with ██████████ listed as the ACV of drug exposed infant and mother listed as AP. It was reported that the mother had used non-prescribed Suboxone throughout her pregnancy. The results of that investigation showed that the mother had in fact been taking non-prescribed Suboxone during her pregnancy and ██████████ tested positive for Suboxone and marijuana on a meconium drug screen. The mother was substantiated as a perpetrator of drug



**Tennessee Department of Children's Services  
Child Protective Service Investigation Summary  
and Classification Decision of Child Abuse/Neglect Referral**

**Case Name :** [REDACTED]

**Investigation ID:** [REDACTED]

exposed infant.

**Summarize any other evidence or factors that support the investigative finding(s) for the allegation(s) of abuse/neglect:**

This file will be submitted for closure to [REDACTED] Lead Investigator of [REDACTED] and [REDACTED] County CPS, as all of the investigative tasks have been completed. All required assessments have also been completed.

**Distribution Copies:** Juvenile Court in All Cases  
District Attorney in Severe Child Abuse Cases  
Regional Supervising Attorney



**Tennessee Department of Children's Services**  
**Case Recording Summary**

Case Id: [REDACTED]	Case Name: [REDACTED]
Case Status: Close	Organization: [REDACTED] Region

**Case Recording Details**

Recording ID: [REDACTED]	Status: Completed
Contact Date: 09/23/2015	Contact Method:
Contact Time: 07:33 PM	Contact Duration:
Entered By: [REDACTED]	Recorded For:
Location:	Created Date: 09/23/2015
Completed date: 09/24/2015	Completed By: [REDACTED]
Purpose(s): Permanency, Safety - Child/Community, Service Planning, Well Being	
Contact Type(s): Notation	
Contact Sub Type:	

**Children Concerning****Participant(s)****Narrative Details**

Narrative Type: Original      Entry Date/Time: 09/23/2015 06:33 PM      Entered By: [REDACTED]

The safety assessment was conditionally safe. The child was deceased and the parents were listed as alleged perpetrators of neglect death as the cause of the infant's death was not known. The parents do not have custody of any of their other children. The Family Functional Assessment has been updated with information from this investigation.

The following documents can be found in the documents portion of this investigation:

Infant's meconium drug test results

Provisional autopsy report

Final autopsy report

Infant's medical records from [REDACTED] Hospital Association, Primary Care Physician/Pediatrician, and [REDACTED] Medical Center (birth hospital)

Mother's prenatal records from [REDACTED] and [REDACTED] and records from The [REDACTED] Medical Center

Photographs taken from the home on 05/19/2015  
 CS-0635 Child Death Summary  
 Child Protective Investigative Team Form 09/09/2015



**Tennessee Department of Children's Services**  
**Case Recording Summary**

Case Id: [REDACTED]  
 Case Status: Close

Case Name: [REDACTED]  
 Organization: [REDACTED] Region

**Case Recording Details**

Recording ID:	[REDACTED]	Status:	Completed
Contact Date:	09/23/2015	Contact Method:	Correspondence
Contact Time:	02:36 PM	Contact Duration:	
Entered By:	[REDACTED]	Recorded For:	
Location:		Created Date:	09/23/2015
Completed date:	09/24/2015	Completed By:	[REDACTED]
Purpose(s):	Service Planning		
Contact Type(s):	Collateral Contact		
Contact Sub Type:			

**Children Concerning**

**Participant(s)**

**Narrative Details**

Narrative Type: Original      Entry Date/Time: 09/23/2015 06:12 PM      Entered By: [REDACTED]

09/23/2015

CPSI contacted [REDACTED] with [REDACTED] regarding the referral CPSI made for services for the parents [REDACTED] and [REDACTED]. CPSI was informed, via email, by [REDACTED] that the number provided by CPSI belongs to the grandmother and she seems to be with the parents very little. She said she has spoken with the grandmother three times but she has been unable to reach the parents. The number provided to [REDACTED] was the number the mother asked CPSI to provide.



**Tennessee Department of Children's Services**  
**Case Recording Summary**

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Case Id: [REDACTED]	Case Name: [REDACTED]
Case Status: Close	Organization: [REDACTED] Region

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**Case Recording Details**

Recording ID: [REDACTED]	Status: Completed
Contact Date: 09/10/2015	Contact Method:
Contact Time: 11:25 AM	Contact Duration:
Entered By: [REDACTED]	Recorded For:
Location: DCS Office	Created Date: 09/10/2015
Completed date: 09/10/2015	Completed By: [REDACTED]
Purpose(s): Service Planning	
Contact Type(s): Administrative Review	
Contact Sub Type:	

**Children Concerning****Participant(s)****Narrative Details**

Narrative Type: Original    Entry Date/Time: 09/10/2015 10:26 AM    Entered By: [REDACTED]

A peer review was held today. Present for the review: [REDACTED] [REDACTED] [REDACTED] [REDACTED]

This case was presented to CPIT on September 9, 2015. Case will be reviewed by LI [REDACTED] for next steps.

Narrative Type: Addendum 1    Entry Date/Time: 09/21/2015 09:52 PM    Entered By: [REDACTED]

This case is being sent to Investigations Coordinator [REDACTED] for review.



**Tennessee Department of Children's Services**  
**Case Recording Summary**

Case Id: [REDACTED]	Case Name: [REDACTED]
Case Status: Close	Organization: [REDACTED] Region

**Case Recording Details**

Recording ID: [REDACTED]	Status: Completed
Contact Date: 09/09/2015	Contact Method:
Contact Time: 03:52 PM	Contact Duration:
Entered By: [REDACTED]	Recorded For:
Location:	Created Date: 09/09/2015
Completed date: 09/18/2015	Completed By: [REDACTED]
Purpose(s): Permanency,Safety - Child/Community,Service Planning,Well Being	
Contact Type(s): Case Summary	
Contact Sub Type:	

**Children Concerning****Participant(s)****Narrative Details**

Narrative Type: Original      Entry Date/Time: 09/09/2015 02:54 PM      Entered By: [REDACTED]

The Tennessee Department of Children's Services (DCS) received a Child Protective Services (CPS) referral on 05/19/2015 with [REDACTED] listed as the alleged child victim (ACV). The allegation was neglect death. The alleged perpetrators (AP) were the infant's parents, [REDACTED] and [REDACTED]. The infant was not in state's custody at the time of the referral and had not been in state's custody at any time prior to the referral.

At the time of the infant's death and new referral, there was an open investigation [REDACTED] with [REDACTED] listed as the ACV of drug exposed infant and mother listed as AP. It was reported that the mother had used non-prescribed Suboxone throughout her pregnancy. The results of that investigation showed that the mother had in fact been taking non-prescribed Suboxone during her pregnancy and [REDACTED] tested positive for Suboxone and marijuana on a meconium drug screen. The mother was substantiated as a perpetrator of drug exposed infant. There were no other cases involving the infant.

In addition to the investigation that was open at the time of the infant's death, the mother had been substantiated as a perpetrator of drug exposed child in 2011 with her older child listed as the ACV. That child was removed from the mother's custody. The father was substantiated in 2013 for drug exposed child and lack of supervision.

[REDACTED] was born on 05/08/2015 at The [REDACTED] Medical Center ([REDACTED] Medical Center) in [REDACTED] TN to parents [REDACTED] and [REDACTED]. He was observed in the hospital for signs of withdrawal due to the mother taking non-prescribed Suboxone while pregnant but was ultimately released without complications. It was reported that [REDACTED] was doing well after discharge. He saw his pediatrician on 05/15/2015 for a new well child visit and again on 05/16/2015 for his circumcision.

Early in the morning on Sunday 05/17/2015, the parents became concerned because the infant was "breathing funny." The child's pediatrician was contacted and the family was advised to go to the emergency room. The mother, father, and infant arrived at [REDACTED] Hospital Emergency Room at 6:41AM. Hospital personnel attempted intubation several times. The infant was pronounced deceased at 9:15 AM.

CPSI [REDACTED] was the assigned CPS Investigator. Detective [REDACTED] with [REDACTED] Sheriff's Office was the law enforcement detective assigned to the case. Detective [REDACTED] reported that he contacted law enforcement with the state and federal governments but there was no agent assigned to the case. After Detective [REDACTED] was no longer



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Case Id: [REDACTED]	Case Name: [REDACTED]
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with the Sheriff's Office, Detective [REDACTED] took over the case.

The alleged perpetrators (AP) were the infant's parents, [REDACTED] and [REDACTED]. Interviews were conducted with the parents, household members, a social worker from [REDACTED] Med Center that had worked with the family, and records were reviewed.

CPSI requested [REDACTED] medical records from [REDACTED] Family Practice [REDACTED] Hospital Association, and [REDACTED] Medical Center. CPSI requested [REDACTED] medical records from [REDACTED] Hospital Association, Women's Wellness and Maternity Center, and [REDACTED] Medical Center.

CPSI reviewed [REDACTED] medical records from [REDACTED] Family Medicine, [REDACTED] pediatrician, on 05/19/2015. [REDACTED] was seen on 05/15/2015 and 05/16/2015 by Dr. [REDACTED]. The appointment on 05/15/2015 was for a new well child check. There were no feeding problems reported and the mother brought a paper log of feedings. His stool was reported to be normal consistency. He was voiding urine well. His breathing pattern was normal, no apnea, and cough denied. There were no concerns of abuse or neglect. He appeared alert and well nourished. He was seen for his circumcision on 05/16/2015. There were no concerns noted and he tolerated the procedure well. Also in the records received was a "progress note" from [REDACTED] Hospital Association dated 05/17/2015 that was completed by Dr. [REDACTED]. The note provided a timeline of events from 05/17/2015, the date of the infant's death. She was contacted at 6:14 AM by the mother who said the infant was "breathing funny" and was waxy and white. Dr. [REDACTED] directed the mother to the closest emergency room and Dr. [REDACTED] arrived by 7:00 AM. She observed a baby that was very pale with supportive breathing and bagging in process. The note then went through a timeline of medical procedures that were completed on the infant. Medical personnel felt there was some foreign body appearing or foreign tube that appeared in the back of the posterior pharynx competing the attempts at intubation. They were not able to pull it out or to figure out what it was exactly that this object was. After coding the infant for 2 ¼ hours without any success and Dr. [REDACTED] noted the infant to have no corneal reflexes, no heartbeat, no breathing spontaneously, no response to painful stimulus, he was pronounced at 9:15 AM.

On 05/19/2015, CPSI and Detective [REDACTED] spoke with maternal grandmother [REDACTED] maternal great-grandmother [REDACTED] and additional household member [REDACTED]. All three reported the infant had behaved normally and the same from the time he was in the hospital until Saturday (05/16/2015) night. They denied any changes in the infant's behavior, feeding, sleeping, bowel movements, or urine output. It was reported that the infant's formula had recently changed on Saturday from Similac Sensitive to Similac Advance. The family reported the mother stopped breastfeeding completely after she learned she was Hepatitis C positive. The family reported no concerns about the care of the child or about the parents.

The provisional autopsy report was received on 05/20/2015. The cause of death was listed as pending. Detective [REDACTED] contacted the medical examiner's office, the [REDACTED] Regional Forensic Center, and Dr. [REDACTED]. The medical examiner's office reported the object found in the child's throat was not medical and they did not know what it was. They said the object was not from their facility. The Forensic Center reported the object found in the child's throat was an endotracheal tube. They said they did not know where the tube came from. Dr. [REDACTED] reported the tube was located in the child's esophagus and into the stomach. He reported there was milk/formula below the tube, above the tube, and clogged in the tube. He reported the tube found in the infant could be a contributing factor in the infant's death. He did not believe the withdrawal symptoms were a contributing factor in the infant's distress or death as signs of withdrawal usually arose within approximately 24 hours.

CPSI spoke with [REDACTED], social worker at [REDACTED] Medical Center after the death of the infant. She denied that the child had any medical issues while he was in the hospital. She denied that he was intubated at any time during his stay in the hospital. She denied that there had been any tubes placed in the infant or that he was intubated.

The parents were interviewed on 05/20/2015. The mother [REDACTED] reported that when she stopped breastfeeding at [REDACTED] Medical Center, they initially started giving [REDACTED] Similac Advance. She said he was fussy that night (Monday the 11th) and he was then switched to Similac Sensitive. She said he was being given the small pre-made bottles of formula. At the time of discharge, she requested formula to take home as her WIC appointment was not until Monday (the 18th). She said they could not provide the Similac Sensitive but she was able to take the remaining bottles that were located in the hospital room. The hospital sent a large bottle of liquid Similac Advance home with the family. Mother denied any changes in the infant's behaviors, feeding, bowel movements, etc. She said they had been



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monitoring him for withdrawal symptoms such as tremors, shaking, and fussiness as advised by [REDACTED] Medical Center. She said he may have spit up only twice while he was at home and it was normal spit up. He was typically given two ounces of formula every three to four hours. On Saturday night the 16th, the mother, father, and infant slept in the same bed. The infant was reportedly wearing a diaper, socks, and a complete onsie with feet. He was also swaddled. The mother reported the infant liked to be swaddled tightly and she had the nurses at the hospital instruct her on how to swaddle him. She denied they used any blankets on the bed that night. She explained that the father was lying on the left side of the bed, the infant was in the right corner, and she was lying perpendicular at the end of the bed. She reported the infant woke up around 2am on the morning of Sunday the 17th. She had run out of the Similac Sensitive and had to make a bottle with the Similac Advance. He took about two ounces and went back to sleep. She said he woke up again around 4am. She did not notice any changes in the infant and had no concerns at that time. She made him another bottle and he took about one ounce. She said he usually drank the whole bottle but was not too worried as he had a full two ounces only two hours earlier. She said he fell back asleep. She said she woke up around 6am. When she woke up, the father [REDACTED] was awake and had his arm stretched to touch the baby. She began to make him a bottle but realized the infant was making an odd sound. She described the sound as a grunting type sound or "uh, uh, uh." It was like he could not catch his breath. She said his eyes were reacting but not his body. She took the infant to her grandmother. They changed the child's diaper. She noticed the child's skin was white. They contacted the child's primary care physician and were advised to take the child to the nearest emergency room. She reported she, the father, and the infant arrived at [REDACTED] Hospital approximately 20 minutes later. The mother said she was not exactly sure what took place at the hospital. She saw the infant with a "thing" over his face to make him breathe. She said later one of the nurses said they were trying to put a tube down his throat. She said medical personnel told her the infant was just having some trouble breathing. She said the doctor asked her if anyone put something in the infant's mouth. She said the doctor said it was like something was blocking his airway. She said she was told when the tube was put in, formula came up. [REDACTED] said the only things that had been placed in the infant's mouth were his passie and bottle.

The father [REDACTED] also denied observing any changes in the infant's behaviors, eating, sleeping, bowel movements, etc. He reported they went to bed on Saturday night the 16th around 10:30 or 11pm. He was not sure exactly what time the infant got up. He said it was 12:30, 1, or 2am [REDACTED] fixed a bottle. Both of them participated in feeding the infant at that time. He was not sure when the infant awoke next as he did not wake up at that time. He said when he woke up that morning, the infant was "breathing funny." He said it was like the infant was in pain. He said the sound was like a half cry or he was short of breath. They took the infant to the emergency room. He said he was initially told by a nurse that the infant was breathing okay. He said a couple of hours later, he died. When questioned about co-sleeping with the infant, he explained that he and the mother were on opposite sides of the bed and the infant slept on his back in between them. He said there was approximately a foot and a half of space between the infant and each of them.

The autopsy report was completed on 08/19/2015. According to the autopsy, [REDACTED] died of acute mitral valve insufficiency due to impaired left ventricular papillary muscle function due to lymphocytic myocarditis. An autopsy revealed a viral infection of the heart muscle associated with a large area of myocyte necrosis within one of the papillary muscles of the left ventricle. This large area of necrosis caused the papillary muscle to improperly function leading to acute mitral valve insufficiency, which explains [REDACTED] initial symptoms and rapid progression to respiratory failure. CPSI made contacted with [REDACTED] Child Safety Nurse, regarding the autopsy results. CPSI was informed that [REDACTED] death could not have been prevented.

The definition of child death/near death according to Work Aid-1 CPS Categories and Definitions of Abuse/Neglect:

Child death is defined as:

- A) Any child death caused by abuse or neglect.
- B) Any unexplained death of a child when the cause of death is unknown or pending an autopsy report.
- C) Any child death caused by abuse or neglect resulting from the parent or caretaker's failure to stop another person's direct action that resulted in the death of the child. Child deaths are always treated as severe abuse.

This case was presented to [REDACTED] County Child Protective Investigative Team (CPIT) on 09/09/2015. The team was in agreement with classifying the allegation of neglect death as allegation unsubstantiated/perpetrator unsubstantiated for both alleged perpetrators.

Based upon the information and evidence gathered during the course of the investigation, there is not a



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Case Name: [REDACTED]

Case Status: Close

Organization: [REDACTED] Region

preponderance of evidence to substantiate the allegation. The infant's autopsy showed that he died of acute mitral valve insufficiency due to impaired left ventricular papillary muscle function due to lymphocytic myocarditis. The autopsy revealed a viral infection of the heart muscle associated with a large area of myocyte necrosis within one of the papillary muscles of the left ventricle. This large area of necrosis caused the papillary muscle to improperly function leading to acute mitral valve insufficiency, which explains [REDACTED] initial symptoms and rapid progression to respiratory failure. The infant's death could not have been prevented [REDACTED] Child Protective Investigative Team was in agreement with the classification.

The case will be closed and classified as allegation unsubstantiated/perpetrator unsubstantiated for the allegation of Child Neglect Death.



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Case Id: [REDACTED]	Case Name: [REDACTED]
Case Status: Close	Organization: [REDACTED] Region

**Case Recording Details**

Recording ID: [REDACTED]	Status: Completed
Contact Date: 09/09/2015	Contact Method: Face To Face
Contact Time: 09:00 AM	Contact Duration:
Entered By: [REDACTED]	Recorded For:
Location: DCS Office	Created Date: 09/09/2015
Completed date: 09/09/2015	Completed By: [REDACTED]
Purpose(s): Permanency, Safety - Child/Community, Service Planning, Well Being	
Contact Type(s): CPIT (Child Protective Investigative Team)	
Contact Sub Type:	

**Children Concerning****Participant(s)****Narrative Details**

Narrative Type: Original      Entry Date/Time: 09/09/2015 01:52 PM      Entered By: [REDACTED]

**CPIT Presentation**

This case was presented to the [REDACTED] CPIT team on 09/09/2015.

**Individuals Present:**

[REDACTED] CPSI, DCS  
 Detective [REDACTED] Sheriff's Office  
 [REDACTED] Judicial District DA's Office  
 [REDACTED] County Juvenile Court  
 [REDACTED] Judicial District CAC

CPSI and Detective [REDACTED] presented the evidence gathered during the course of the investigation. The team was in agreement with classifying the allegations of neglect death with [REDACTED] listed as the alleged child victim and parents [REDACTED] and [REDACTED] listed as the alleged perpetrators as allegation unsubstantiated/perpetrator unsubstantiated.

The CPIT forms can be found in the documents portion of this investigation.



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**Case Recording Summary**

Case Id: [REDACTED]	Case Name: [REDACTED]
Case Status: Close	Organization: [REDACTED] Region

**Case Recording Details**

Recording ID: [REDACTED]	Status: Completed
Contact Date: 08/28/2015	Contact Method: Phone Call
Contact Time: 02:00 PM	Contact Duration:
Entered By: [REDACTED]	Recorded For:
Location: Other Community Site	Created Date: 09/09/2015
Completed date: 09/09/2015	Completed By: [REDACTED]
Purpose(s): Permanency,Safety - Child/Community,Service Planning,Well Being	
Contact Type(s): Parent/Caretaker Interview	
Contact Sub Type:	

**Children Concerning****Participant(s)****Narrative Details**

Narrative Type: Original      Entry Date/Time: 09/09/2015 02:04 PM      Entered By: [REDACTED]

08/28/2015  
2:00 PM

The maternal great-grandmother [REDACTED] was the only one to show up at the [REDACTED] County Sheriff's Office on this date. [REDACTED] contacted [REDACTED] and [REDACTED] via telephone call and was informed that neither of them were going to be able to make it due to work. [REDACTED] reported that both parents had lost their jobs and were doing odd jobs for income. CPSI spoke with [REDACTED] on the phone and she agreed to participate by phone and allow [REDACTED] to receive information. [REDACTED] was placed on speaker phone with CPSI, Detective [REDACTED] and [REDACTED] and [REDACTED] reported that [REDACTED] pediatrician, Dr. [REDACTED] had contacted them and explained to them the cause of death [REDACTED] said it was explained to her that [REDACTED] had an infection that went to his hurt and turned his white cells into "mush." CPSI informed [REDACTED] there was no evidence to substantiate that she or [REDACTED] had done anything to cause the death and that it appeared there was nothing to prevent the death. CPSI asked [REDACTED] if she had any questions [REDACTED] said no. She then asked about the tube that she had been told was found in [REDACTED] esophagus. Detective [REDACTED] told [REDACTED] that according to the autopsy report, that did not cause [REDACTED] death.

CPSI did speak with [REDACTED] about services. She reported her and [REDACTED] quit the Suboxone treatment program about a month ago. She agreed to services. CPSI and [REDACTED] discussed the [REDACTED] program which they had discussed during their first meeting at the hospital when [REDACTED] was born. [REDACTED] told CPSI that CPSI could make that referral and to list her grandmother's address and phone number as contact information [REDACTED] reported there was nothing else she believed the Department could do or provide at this time.

After the phone call with [REDACTED] ended, [REDACTED] cried and said she had been praying that [REDACTED] would finally get help. She said she believes [REDACTED] needs counseling. She said she believes that [REDACTED] had relapsed a couple of times. She said she was thankful that [REDACTED] finally agreed to get help.

CPSI did send a referral via email to [REDACTED] [REDACTED] for [REDACTED] and [REDACTED] [REDACTED] for the in-home [REDACTED] Program to address substance abuse, mental health, and parenting.



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Case Id: [REDACTED]

Case Name: [REDACTED]

Case Status: Close

Organization: [REDACTED] Region

**Case Recording Details**

Recording ID:	[REDACTED]	Status:	Completed
Contact Date:	08/26/2015	Contact Method:	
Contact Time:	12:46 PM	Contact Duration:	
Entered By:	[REDACTED]	Recorded For:	
Location:		Created Date:	09/09/2015
Completed date:	09/09/2015	Completed By:	[REDACTED]
Purpose(s):	Service Planning		
Contact Type(s):	Notation		
Contact Sub Type:			

**Children Concerning**

**Participant(s)**

**Narrative Details**

Narrative Type: Original      Entry Date/Time: 09/09/2015 02:05 PM      Entered By: [REDACTED]

08/26/2015  
12:46 PM

CPSI spoke with Detective [REDACTED] He reported he had spoken with the [REDACTED] family and scheduled a meeting with them for 8/28/2015 at 2:00 PM.



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**Case Recording Summary**

Case Id: [REDACTED]  
 Case Status: Close

Case Name: [REDACTED]  
 Organization: [REDACTED] Region

**Case Recording Details**

Recording ID: [REDACTED] Status: Completed  
 Contact Date: 08/25/2015 Contact Method: Attempted Phone Call  
 Contact Time: 09:53 AM Contact Duration:  
 Entered By: [REDACTED] Recorded For:  
 Location: Created Date: 08/25/2015  
 Completed date: 09/05/2015 Completed By: [REDACTED]  
 Purpose(s): Service Planning  
 Contact Type(s): Parent/Caretaker Interview  
 Contact Sub Type:

**Children Concerning**

**Participant(s)**

**Narrative Details**

Narrative Type: Original Entry Date/Time: 08/25/2015 08:56 AM Entered By: [REDACTED]  
 08/25/2015  
 9:53 AM

CPSI attempted to speak with [REDACTED] ([REDACTED]). CPSI received a message that the number had been changed, disconnected, or was no longer in service.



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Case Id: [REDACTED]	Case Name: [REDACTED]
Case Status: Close	Organization: [REDACTED] Region

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**Case Recording Details**

Recording ID: [REDACTED]	Status: Completed
Contact Date: 08/24/2015	Contact Method:
Contact Time: 01:35 PM	Contact Duration:
Entered By: [REDACTED]	Recorded For:
Location: DCS Office	Created Date: 08/24/2015
Completed date: 08/24/2015	Completed By: [REDACTED]
Purpose(s): Service Planning	
Contact Type(s): Administrative Review	
Contact Sub Type:	

**Children Concerning****Participant(s)****Narrative Details**

Narrative Type: Original      Entry Date/Time: 08/24/2015 12:38 PM      Entered By: [REDACTED]

A peer review was held today. Present for the review was LI [REDACTED] LI [REDACTED] and IC [REDACTED]. The autopsy was received today and sent to DCS Nurse [REDACTED] for review. This case will need to be presented to the next [REDACTED] County CPIT meeting for further review to determine classification. CPSI will continue to try and locate parents about grief counseling.



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**Case Recording Summary**

Case Id: [REDACTED]	Case Name: [REDACTED]
Case Status: Close	Organization: [REDACTED] Region

**Case Recording Details**

Recording ID: [REDACTED]	Status: Completed
Contact Date: 08/24/2015	Contact Method: Correspondence
Contact Time: 01:04 PM	Contact Duration:
Entered By: [REDACTED]	Recorded For:
Location:	Created Date: 08/25/2015
Completed date: 09/05/2015	Completed By: [REDACTED]
Purpose(s): Permanency,Safety - Child/Community,Service Planning,Well Being	
Contact Type(s): Collateral Contact,Notation	
Contact Sub Type:	

**Children Concerning****Participant(s)****Narrative Details**

Narrative Type: Original      Entry Date/Time: 08/25/2015 09:14 AM      Entered By: [REDACTED]

08/24/2015

CPSI sent the autopsy report for [REDACTED] to [REDACTED], Child Safety Nurse, for review.

[REDACTED] replied to CPSI, via email, and provided an explanation of the medical findings to CPSI. [REDACTED] stated, after reviewing the results, that [REDACTED] had an inflammatory disease of his heart muscle. The valve between the chambers of the heart did not close properly, allowing blood to back up in the atrium. When this happens, it causes increased pressure in the vessels that bring blood from the lungs to the heart. This causes an increase in fluid buildup in the lungs (pulmonary edema). With fluid in the lungs, air can not exchange and death will occur. She also stated that the usual causes of disease of the heart muscle are viral but can be caused from toxins or an autoimmune process.

CPSI replied to [REDACTED] via email and asked if CPSI was correct in assuming this was nothing that could have been prevented.

[REDACTED] replied to CPSI and said yes, CPSI was correct. She said it was most likely a viral infection that he had prior to or immediately after birth, that attacked his heart muscle and damaged the valve. Nothing could have prevented it.

08/24/2015

CPSI contacted Detective [REDACTED] with [REDACTED] County Sheriff's Office regarding the autopsy report. CPSI informed Detective [REDACTED] of the findings of the autopsy. CPSI and Detective [REDACTED] will attempt to make contact with the family to review the results of the investigation.



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Case Id: [REDACTED]	Case Name: [REDACTED]
Case Status: Close	Organization: [REDACTED] Region

**Case Recording Details**

Recording ID: [REDACTED]	Status: Completed
Contact Date: 08/24/2015	Contact Method: Correspondence
Contact Time: 12:30 PM	Contact Duration:
Entered By: [REDACTED]	Recorded For:
Location:	Created Date: 08/25/2015
Completed date: 08/25/2015	Completed By: [REDACTED]
Purpose(s): Permanency, Safety - Child/Community, Service Planning, Well Being	
Contact Type(s): Collateral Contact, Notation	
Contact Sub Type:	

**Children Concerning****Participant(s)****Narrative Details**

Narrative Type: Original      Entry Date/Time: 08/25/2015 09:08 AM      Entered By: [REDACTED]  
08/24/2015

CPSI reviewed the final autopsy report received on [REDACTED]. The report was received via fax from [REDACTED] County Regional Forensic Center. The date of the report was 08/19/2015.

\*\*The entire report can be found in the documents portion of this investigation.\*\*

**Final Anatomic Diagnosis**

- I. Lymphocytic myocarditis involving left ventricular papillary muscle
  - A. Acute mitral valve insufficiency
    1. Pulmonary edema
    2. Clinical history of respiratory distress followed by cardiopulmonary arrest

**Other findings:**

- I. Circumcision, recent

**Narrative**

This 9-day-old boy, [REDACTED], died of acute mitral valve insufficiency due to impaired left ventricular papillary muscle function due to lymphocytic myocarditis.

By report, on May 17, 2015 at 04:00 hours, [REDACTED] mother noted that he would not eat much and was making funny noises. At 06:00 hours, [REDACTED] was still making funny noises, was not acting normally, and would not ingest his formula. She drove to [REDACTED] emergency room arriving at 06:41 hours. After arrival, [REDACTED] rapidly declined and required cardiopulmonary resuscitation. Multiple attempts were made at endotracheal intubation. Despite medical intervention he was pronounced dead at 09:15 hours. His mother stated that he appeared fine all evening on May 16, 2015. His birth records and postnatal records (prior to this event) are unremarkable other than for maternal drug use.

An autopsy revealed a viral infection of the heart muscle associated with a large area of myocyte necrosis within one of the papillary muscles of the left ventricle. This large area of necrosis caused the papillary muscle to improperly function leading to acute mitral valve insufficiency, which explains [REDACTED] initial symptoms and rapid progression to



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Case Id: [REDACTED]

Case Name: [REDACTED]

Case Status: Close

Organization: [REDACTED] Region

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respiratory failure.

Toxicologic analysis of postmortem liver tissue revealed no alcohol, drugs of abuse, or medications. Analysis of the vitreous fluid was negative for an electrolyte abnormality. Postmortem viral and bacterial cultures were negative. Total body radiographs were negative for acute or remote bony trauma.



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Case Id: [REDACTED]	Case Name: [REDACTED]
Case Status: Close	Organization: [REDACTED] Region

**Case Recording Details**

Recording ID: [REDACTED]	Status: Completed
Contact Date: 08/12/2015	Contact Method:
Contact Time: 10:00 AM	Contact Duration:
Entered By: [REDACTED]	Recorded For:
Location:	Created Date: 08/13/2015
Completed date: 08/24/2015	Completed By: [REDACTED]
Purpose(s): Permanency,Safety - Child/Community,Service Planning,Well Being	
Contact Type(s): Notation	
Contact Sub Type:	

**Children Concerning****Participant(s)****Narrative Details**

Narrative Type: Original      Entry Date/Time: 08/13/2015 09:44 AM      Entered By: [REDACTED]

08/12/2015

Detective [REDACTED] with [REDACTED] County Sheriff's Office informed CPSI on this date that he and Sheriff [REDACTED] met with the parents [REDACTED] and [REDACTED] last Thursday evening (08/06/2015) regarding the case. He reported they went out to the home to speak with the parents. He reported that if the endotracheal tube was what caused [REDACTED] death that the Sheriff's Office and DA's office would not be pursuing prosecution because it would be a malpractice case, civil issue. He said they informed the parents they believed that was what caused [REDACTED] death. He said they advised the parents to wait for the autopsy and then speak with an attorney. He said the parents did appear upset and cried but also appeared relieved that they had not done anything to cause the death.



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Case Id: [REDACTED]	Case Name: [REDACTED]
Case Status: Close	Organization: [REDACTED] Region

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**Case Recording Details**

Recording ID: [REDACTED]	Status: Completed
Contact Date: 07/31/2015	Contact Method: Attempted Phone Call
Contact Time: 08:34 AM	Contact Duration:
Entered By: [REDACTED]	Recorded For:
Location:	Created Date: 07/31/2015
Completed date: 07/31/2015	Completed By: [REDACTED]
Purpose(s): Service Planning	
Contact Type(s): Alleged Perpetrator Interview, Parent/Caretaker Interview	
Contact Sub Type:	

**Children Concerning****Participant(s)****Narrative Details**

Narrative Type: Original      Entry Date/Time: 07/31/2015 02:45 PM      Entered By: [REDACTED]  
07/31/2015  
8:34 AM  
Attempted contact with [REDACTED]

CPSI attempted to reach the mother [REDACTED] by phone. There was no answer. CPSI sent a text message to [REDACTED] asking if she was free to meet with CPSI.



**Tennessee Department of Children's Services**  
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Case Id: [REDACTED]	Case Name: [REDACTED]
Case Status: Close	Organization: [REDACTED] Region

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**Case Recording Details**

Recording ID: [REDACTED]	Status: Completed
Contact Date: 07/23/2015	Contact Method:
Contact Time: 01:20 PM	Contact Duration:
Entered By: [REDACTED]	Recorded For:
Location: DCS Office	Created Date: 07/23/2015
Completed date: 07/23/2015	Completed By: [REDACTED]
Purpose(s): Service Planning	
Contact Type(s): Administrative Review	
Contact Sub Type:	

**Children Concerning****Participant(s)****Narrative Details**

Narrative Type: Original      Entry Date/Time: 07/23/2015 10:24 PM      Entered By: [REDACTED]

Case staffed with CPSI [REDACTED] on this date. At this time, the autopsy still has not been completed. CPSI has followed up with the deceased child's half-sibling and extended family. CPSI has attempted to make contact with the parents in regard to services and resources. CPSI will continue attempts to meet with the parents. This case has been reassigned to Detective [REDACTED] with [REDACTED] County Sheriff's Office. CPSI has met with Detective [REDACTED] and has reviewed the case. CPSI will continue to check for updates on the autopsy report. At this time, the FBI and TBI are not involved.



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Case Id: [REDACTED]	Case Name: [REDACTED]
Case Status: Close	Organization: [REDACTED] Region

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**Case Recording Details**

Recording ID: [REDACTED]	Status: Completed
Contact Date: 07/22/2015	Contact Method: Phone Call
Contact Time: 12:20 PM	Contact Duration:
Entered By: [REDACTED]	Recorded For:
Location:	Created Date: 07/31/2015
Completed date: 07/31/2015	Completed By: [REDACTED]
Purpose(s): Permanency, Safety - Child/Community, Service Planning, Well Being	
Contact Type(s): Collateral Contact	
Contact Sub Type:	

**Children Concerning****Participant(s)****Narrative Details**

Narrative Type: Original      Entry Date/Time: 07/31/2015 02:40 PM      Entered By: [REDACTED]

07/22/2015  
12:20 PM

TC [REDACTED] County Regional Forensic Center

CPSI spoke with [REDACTED] at the Regional Forensic Center and inquired as to the status of [REDACTED] autopsy report. CPSI was informed that the autopsy was not complete.



**Tennessee Department of Children's Services**  
**Case Recording Summary**

Case Id: [REDACTED]  
 Case Status: Close

Case Name: [REDACTED]  
 Organization: [REDACTED] Region

**Case Recording Details**

Recording ID: [REDACTED] Status: Completed  
 Contact Date: 07/20/2015 Contact Method: Attempted Phone Call  
 Contact Time: 08:51 AM Contact Duration:  
 Entered By: [REDACTED] Recorded For:  
 Location: Created Date: 07/31/2015  
 Completed date: 07/31/2015 Completed By: [REDACTED]  
 Purpose(s): Service Planning  
 Contact Type(s): Alleged Perpetrator Interview, Parent/Caretaker Interview  
 Contact Sub Type:

**Children Concerning****Participant(s)****Narrative Details**

Narrative Type: Original Entry Date/Time: 07/31/2015 02:43 PM Entered By: [REDACTED]

07/20/2015  
 8:51 AM

CPSI had a note left for her. It read:

[REDACTED]  
 call twice  
 working third shift

CPSI attempted to speak with [REDACTED] at the number provided and called the number twice as requested. CPSI left a voicemail.



**Tennessee Department of Children's Services**  
**Case Recording Summary**

Case Id: [REDACTED]  
Case Status: Close

Case Name: [REDACTED]  
Organization: [REDACTED] Region

**Case Recording Details**

Recording ID: [REDACTED] Status: Completed  
Contact Date: 07/16/2015 Contact Method: Attempted Face To Face  
Contact Time: 09:00 AM Contact Duration:  
Entered By: [REDACTED] Recorded For:  
Location: DCS Office Created Date: 07/31/2015  
Completed date: 07/31/2015 Completed By: [REDACTED]  
Purpose(s): Permanency, Safety - Child/Community, Service Planning, Well Being  
Contact Type(s): Alleged Perpetrator Interview, Parent/Caretaker Interview  
Contact Sub Type:

**Children Concerning**

**Participant(s)**

**Narrative Details**

Narrative Type: Original Entry Date/Time: 07/31/2015 02:31 PM Entered By: [REDACTED]

07/16/2015

Neither parent came to the [REDACTED] DCS Office on this date as scheduled the previous day.



**Tennessee Department of Children's Services**  
**Case Recording Summary**

Case Id: [REDACTED]	Case Name: [REDACTED]
Case Status: Close	Organization: [REDACTED] Region

**Case Recording Details**

Recording ID: [REDACTED]	Status: Completed
Contact Date: 07/15/2015	Contact Method: Face To Face
Contact Time: 05:15 PM	Contact Duration:
Entered By: [REDACTED]	Recorded For:
Location: Family Home	Created Date: 07/31/2015
Completed date: 07/31/2015	Completed By: [REDACTED]
Purpose(s): Permanency,Safety - Child/Community,Service Planning,Well Being	
Contact Type(s): Collateral Contact,Sibling Interview/Observation	
Contact Sub Type:	

**Children Concerning****Participant(s)****Narrative Details**

Narrative Type: Original      Entry Date/Time: 07/31/2015 02:48 PM      Entered By: [REDACTED]

07/15/2015  
5:15 PM

CPSI completed an unannounced visit to the home of [REDACTED] located at [REDACTED] TN as a follow up for investigation [REDACTED] [REDACTED] half-sister [REDACTED] was present along with [REDACTED] half-sister [REDACTED] [REDACTED] was not present at the home on this date; she was reported to be at work. The children were being watched by [REDACTED] daughter [REDACTED] and [REDACTED] boyfriend [REDACTED]

CPSI was greeted outside by [REDACTED] [REDACTED] reported her mother was at work and she was watching the children, [REDACTED] and [REDACTED] She said she was about to take the children to her mother at work.

The children came outside and greeted CPSI. Both children had their hair cut much shorter than the last time CPSI saw them. [REDACTED] was friendly and more talkative with CPSI and immediately began interacting with CPSI. CPSI talked to the girls about their hair cuts and how things were going in the summer. [REDACTED] had spent two weeks with extended family in [REDACTED] recently. CPSI asked [REDACTED] about counseling. She said [REDACTED] (with [REDACTED]) had only talked to her one time. She is going to [REDACTED] [REDACTED] for mental health services. CPSI asked [REDACTED] how visits with her mom were going [REDACTED] said good. She reported her mom was doing well and there were no issues. She denied concerns of drug use [REDACTED] went inside the home and retrieved a picture of her and [REDACTED] to show CPSI [REDACTED] began to cry while looking at the picture and talking about her brother.

CPSI spoke with [REDACTED]. She reported [REDACTED] was participating in counseling. She said the mother [REDACTED] appeared to be doing well in regards to not using or abusing substances but was still in need of mental health services to help work through the death of her son. She said [REDACTED] is not asking for help at this time. [REDACTED] came outside and introduced himself as [REDACTED] boyfriend [REDACTED] and [REDACTED] had to leave to take the children to [REDACTED] as [REDACTED] had to go to work. CPSI left her name and number with [REDACTED]. CPSI informed [REDACTED] that if she needed any services or resources or had concerns, she could contact CPSI.



**Tennessee Department of Children's Services**  
**Case Recording Summary**

Case Id: [REDACTED] Case Name: [REDACTED]  
Case Status: Close Organization: [REDACTED] Region

**Case Recording Details**

Recording ID: [REDACTED] Status: Completed  
Contact Date: 07/15/2015 Contact Method: Face To Face  
Contact Time: 12:50 PM Contact Duration:  
Entered By: [REDACTED] Recorded For:  
Location: Family Home Created Date: 07/31/2015  
Completed date: 07/31/2015 Completed By: [REDACTED]  
Purpose(s): Permanency,Safety - Child/Community,Service Planning,Well Being  
Contact Type(s): Collateral Contact,Other Persons Living in Home Interview/Observation  
Contact Sub Type:

**Children Concerning****Participant(s)****Narrative Details**

Narrative Type: Original Entry Date/Time: 07/31/2015 02:27 PM Entered By: [REDACTED]

07/15/2015

12:50 PM

Type of Contact Attempted F2F with parents; F2F with other household members

Location Family Home; [REDACTED]

Present Maternal Grandmother [REDACTED], Maternal Great-Grandmother [REDACTED], other household member [REDACTED]

Not Present: Mother [REDACTED] Father [REDACTED]

**Documentation of Contact:**

CPSI completed an unannounced visit to the family home located at [REDACTED] on this date. CPSI was greeted by maternal grandmother [REDACTED] and invited into the home. CPSI inquired as to the status of parents [REDACTED] and [REDACTED]. [REDACTED] reported that [REDACTED] and [REDACTED] still stayed at the home sometimes but also stayed in other various places. She said the parents do not like being in the home since [REDACTED] death. She said there were still baby items in the spare room in the home. She said [REDACTED] was working at [REDACTED] in [REDACTED] and [REDACTED] was still employed. She said both of them had a doctor's appointment on this date for their prescriptions of suboxone. She said it was her understanding that both of them were participating in individual and marriage counseling. CPSI asked [REDACTED] if she was receiving any services for herself. [REDACTED] reported they had increased her counseling to every other week.

[REDACTED] reported things had been difficult for the family recently since the death of [REDACTED]. She said two weeks after [REDACTED] died, her father passed away and they were dealing with life insurance and other things. She talked about her health status. She said she has started smoking marijuana again just so she could eat and gain weight. CPSI noticed that [REDACTED] did appear healthier on this date than the last face to face contact. [REDACTED] denied that she ever smoked marijuana while her granddaughter [REDACTED] was present in the home. She said she kept the substance hidden in her room in a high location where no one could find it.

Household member [REDACTED] returned home and shortly after that the maternal great-grandmother [REDACTED] came



**Tennessee Department of Children's Services**  
**Case Recording Summary**

Case Id: [REDACTED]

Case Name: [REDACTED]

Case Status: Close

Organization: [REDACTED] Region

into the living room [REDACTED] was on the phone with [REDACTED] and reported [REDACTED] had an abscessed tooth that needed treatment [REDACTED] allowed CPSI to speak with [REDACTED] on the phone to schedule a time to meet the next morning at the DCS office.

After the phone call, [REDACTED] began to question CPSI about the investigation into [REDACTED] death. She said she had attempted to speak with Detective [REDACTED] regarding the investigation but had been unable to reach him. She said she finally made contact with the Sheriff, [REDACTED], and spoke with him about the investigation. [REDACTED] said Detective [REDACTED] had taken some formula from the home to be tested. She said he told he was going to send the formula to the TBI lab instead of the Medical Examiner's Office because the TBI lab had better testing. [REDACTED] said she did not understand why TBI then could not do all of the testing. CPSI told [REDACTED] that she was unable to answer those questions due to lack of knowledge. CPSI also informed [REDACTED] that a new Detective was on the case, [REDACTED], so she could contact him with future questions [REDACTED] kept saying she just wanted to know what happened to [REDACTED] CPSI explained that she could not provide specific details about the investigation but investigations into deaths can take several months due to waiting on the autopsy report. CPSI informed the household members that the Department would continue to be involved in the investigation until after the autopsy report was received. CPSI also told the family that if they needed any services or resources or had questions, they could contact CPSI.

[REDACTED] reported [REDACTED] was doing well in regards to drugs but was still struggling with the death of [REDACTED] She and [REDACTED] reported everyone was worried that [REDACTED] would go back to using drugs but she has not. [REDACTED] said she did not like that [REDACTED] was going to a suboxone clinic but was happy that she had not reverted back to abusing pain medication. She said she was not sure [REDACTED] was ready to go back to work but that's what [REDACTED] wanted. [REDACTED] said it was her understanding that neither [REDACTED] nor [REDACTED] had actually begun counseling. She said both were supposed to be working with their insurance about therapy. She said she would like for them to be able to work with services closer to home. CPSI discussed service options with the family. CPSI told [REDACTED] that she could provide resources to [REDACTED] and [REDACTED]

CPSI left her card with contact information once again for the family on this date.



**Tennessee Department of Children's Services**  
**Case Recording Summary**

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Case Id: [REDACTED]	Case Name: [REDACTED]
Case Status: Close	Organization: [REDACTED] Region

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**Case Recording Details**

Recording ID: [REDACTED]	Status: Completed
Contact Date: 07/15/2015	Contact Method: Attempted Face To Face
Contact Time: 12:50 PM	Contact Duration:
Entered By: [REDACTED]	Recorded For:
Location: Family Home	Created Date: 07/31/2015
Completed date: 07/31/2015	Completed By: [REDACTED]
Purpose(s): Permanency, Safety - Child/Community, Service Planning, Well Being	
Contact Type(s): Alleged Perpetrator Interview, Parent/Caretaker Interview	
Contact Sub Type:	

**Children Concerning****Participant(s)****Narrative Details**

Narrative Type: Original      Entry Date/Time: 07/31/2015 02:30 PM      Entered By: [REDACTED]

07/15/2015  
12:50 PM

CPSI attempted to make contact with the parents [REDACTED] and [REDACTED] on this date at the family home. CPSI was informed by other household members that neither parent was present in the home. CPSI was able to speak with the mother on the phone and schedule a meeting at the [REDACTED] County DCS Office for the next morning between 8:30 and 9:00 AM.



**Tennessee Department of Children's Services**  
**Case Recording Summary**

Case Id: [REDACTED]	Case Name: [REDACTED]
Case Status: Close	Organization: [REDACTED] Region

**Case Recording Details**

Recording ID: [REDACTED]	Status: Completed
Contact Date: 07/15/2015	Contact Method: Face To Face
Contact Time: 11:40 AM	Contact Duration:
Entered By: [REDACTED]	Recorded For:
Location: Other Community Site	Created Date: 07/31/2015
Completed date: 07/31/2015	Completed By: [REDACTED]
Purpose(s): Permanency,Safety - Child/Community,Service Planning,Well Being	
Contact Type(s): CPIT (Child Protective Investigative Team)	
Contact Sub Type:	

**Children Concerning****Participant(s)****Narrative Details**

Narrative Type: Original      Entry Date/Time: 07/31/2015 02:37 PM      Entered By: [REDACTED]  
 07/15/2015  
 11:40 AM  
 TC & F2F Detective [REDACTED]

CPSI was contacted by Detective [REDACTED] on this date. He reported he was going through some paperwork and asked to meet with CPSI regarding this case. CPSI met with Detective [REDACTED] at his office located at the [REDACTED] Sheriff's Department. Detective [REDACTED] was going through the medical records that had been subpoenaed previously by Detective [REDACTED]. Detective [REDACTED] reported he was not aware of the FBI or TBI being involved at this time. He said Detective [REDACTED] told him he did not receive a call back from the FBI. Detective [REDACTED] and CPSI agreed that the autopsy would need to be completed and received before more investigative tasks could take place. CPSI will continue to work with Detective [REDACTED] regarding this investigation.



**Tennessee Department of Children's Services**  
**Case Recording Summary**

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Case Id: [REDACTED]	Case Name: [REDACTED]
Case Status: Close	Organization: [REDACTED] Region

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**Case Recording Details**

Recording ID: [REDACTED]	Status: Completed
Contact Date: 06/17/2015	Contact Method:
Contact Time: 04:44 PM	Contact Duration:
Entered By: [REDACTED]	Recorded For:
Location: DCS Office	Created Date: 06/17/2015
Completed date: 06/17/2015	Completed By: [REDACTED]
Purpose(s): Service Planning	
Contact Type(s): Administrative Review	
Contact Sub Type:	

**Children Concerning****Participant(s)****Narrative Details**

Narrative Type: Original      Entry Date/Time: 06/17/2015 03:46 PM      Entered By: [REDACTED]

At this time the autopsy is not complete. According to Detective [REDACTED] has been in contact with the FBI in regards to the case and the tubing in the child's throat. CPSI will continue to work with law enforcement on the case. CPSI has spoke with the parents about counseling and services.



**Tennessee Department of Children's Services**  
**Case Recording Summary**

Case Id: [REDACTED]	Case Name: [REDACTED]
Case Status: Close	Organization: [REDACTED] Region

**Case Recording Details**

Recording ID: [REDACTED]	Status: Completed
Contact Date: 05/21/2015	Contact Method:
Contact Time: 03:00 PM	Contact Duration: Less than 30
Entered By: [REDACTED]	Recorded For:
Location: DCS Office	Created Date: 05/28/2015
Completed date: 05/28/2015	Completed By: [REDACTED]
Purpose(s): Service Planning	
Contact Type(s): Administrative Review	
Contact Sub Type:	

**Children Concerning****Participant(s)****Narrative Details**

Narrative Type: Original      Entry Date/Time: 05/28/2015 03:09 PM      Entered By: [REDACTED]

IC [REDACTED], RID [REDACTED], and CPSI [REDACTED] staffed this case on this date. The preliminary autopsy showed that there was a partial tube lodged in the esophagus rather than the trachea, which is concerning. There are several things still pending from the autopsy, including toxicology reports, as well as the cause of death. There is currently active involvement with the Sheriff's Department, the DAs office, and DCS. At this time, TBI is not actively involved, but they have been made aware of the situation. The mother has one other child, who is 9 years old, but is in the custody of her paternal grandparents due to prior drug issues of the mother. The father has 4 other children, but he does not have custody of any of them.

CPSI has talked with the mother about services for parenting, substance abuse, and mental health treatment. The mother is not very receptive to much at this time, but CPSI will try to engage the mother and the father regarding grief counseling and any other services that they feel that they may need.



**Tennessee Department of Children's Services**  
**Case Recording Summary**

Case Id: [REDACTED] Case Name: [REDACTED]  
Case Status: Close Organization: [REDACTED] Region

**Case Recording Details**

Recording ID: [REDACTED] Status: Completed  
Contact Date: 05/21/2015 Contact Method: Correspondence  
Contact Time: 11:43 AM Contact Duration: Less than 05  
Entered By: [REDACTED] Recorded For:  
Location: Created Date: 05/26/2015  
Completed date: 06/19/2015 Completed By: [REDACTED]  
Purpose(s): Permanency,Safety - Child/Community,Service Planning,Well Being  
Contact Type(s): Collateral Contact  
Contact Sub Type:

**Children Concerning**

**Participant(s)**

**Narrative Details**

Narrative Type: Original Entry Date/Time: 05/26/2015 09:38 AM Entered By: [REDACTED]

05/21/2015

CPSI received [REDACTED] medical records from [REDACTED] Hospital Association. [REDACTED] was seen on 05/17/2015.  
The records received have been scanned into the documents portion of this investigation.

Information from the records received can be found below. Please see the file or the documents section for the full record.

**Nurse's Notes**

Arrival time was listed as 06:41. Diagnosis was listed as Acute Respiratory Distress/Insufficiency; Bradycardia; Cardiopulmonary Resuscitation. The presenting complaint: "Mother states: child is just not acting right. Baby appears pale in color." During triage assessment at 06:50, is says "appears in no apparent distress, uncomfortable, Behavior is fussy." It also said he was noted to be crying. Skin is pale. Skin temperature is warm.

**ED Course:**

06:41 Patient arrived in ED.  
06:49 Triage completed.  
05:52 [REDACTED] RN is Primary Nurse.  
06:56 [REDACTED] MD is Attending Physician.  
06:58 Dr. [REDACTED] speaking with Dr. [REDACTED] with [REDACTED] about transferring pt.  
07:00 Missed attempts: 24 gauge X 1 in left hand, per [REDACTED] RN.  
07:01 simple mask placed at this time.  
07:02 ED physician to see patient. Respiratory Care Therapist to see patient. lab. house supervisor [REDACTED]  
07:05 Missed attempts: 22 gauge X 1 in right antecubital area, per [REDACTED] RN.  
07:07 Assist ventilation with newborn Ambu bag.  
07:16 Missed attempts: 24 gauge X 1 in right antecubital area, per [REDACTED] RN.  
07:18 An og tube placed down left nare at this time.  
07:21 Assist ventilation with newborn Ambu bag.  
07:23 Pt's heart rate at this time is 136 and SAT of 90%  
07:26 Assist ventilation with newborn Ambu bag.  
07:29 Og tube removed at this time.



**Tennessee Department of Children's Services**  
**Case Recording Summary**

Case Id: [REDACTED]  
 Case Status: Close

Case Name: [REDACTED]  
 Organization: [REDACTED] Region

07:30 [REDACTED] attempting to intubate at this time with no success.  
 07:30 Suctioned, orally, collected moderate amount of thick white substance consistent with formula  
 07:31 Assisted provider with intubation with 4.0 mm ETT. via right nares. Assist ventilation with newborn Ambu bag. Intubated by [REDACTED] actual tube size was 3.0 and with the CO2 detector not changing color. Suctioned, nasally, collected moderate amount of thick white formula.  
 07:32 Assist ventilation with newborn Ambu bag.  
 07:33 Chest 1v Ordered.  
 07:35 Suctioned, nasally, collected moderate amount of thick white substance consistent with formula.  
 07:36 [REDACTED] attempting to intubate at this time with no success.  
 07:37 Assisted provider with intubation with 4.0 mm ETT. via oral route. Assist ventilation with newborn Ambu bag. Intubated by [REDACTED] actual tube size was 3.0 and CO2 detector not changing color.  
 07:38 Suctioned, nasally, collected moderate amount of thick white substance consistent with formula Assist ventilation with newborn Ambu bag.  
 07:39 Awaiting x-ray  
 07:40 Dr. [REDACTED] performing compressions at this time. ET tube no longer in place.  
 07:41 Assisted provider with intubation with 4.0 mm ETT. via oral route. Assist ventilation with newborn Ambu bag. Intubated by [REDACTED] actual tube size is 3.0 and CO2 detector not changing color.  
 07:42 Dr. [REDACTED] performing compression at this time.  
 07:44 ET tube removed at this time due to no longer being in place.  
 07:44 Assist ventilation with newborn Ambu bag. Suctioned, nasally, collected moderate amount of thick white substance consistent with formula.  
 07:46 Suctioned, nasally, collected moderate amount of thick white substance consistent with formula Assist ventilation with newborn Ambu bag.  
 07:47 Pt turned to right side at this time.  
 07:48 Inserted intraosseous access 15mm in right tibial tuberosity.  
 07:49 Dr. [REDACTED] attempting to intubate at this time with no success.  
 07:50 Awaiting transportation, [REDACTED] transportation is on their way to our facility.  
 07:51 [REDACTED] performing compressions at this time. Dr. [REDACTED] attempted to intubate with no success at this time.  
 07:51 Assist ventilation with newborn Ambu bag.  
 07:52 Pt's heart rate at this time is 120.  
 07:52 Assist ventilation with newborn Ambu bag.  
 07:53 [REDACTED] attempting to intubate at this time.  
 07:54 Assisted provider with intubation with 2.0 mm ETT. via oral route. Assist ventilation with newborn Ambu bag. Intubated by [REDACTED] actual tube size was 2.5 and CO2 detector not changing color.  
 07:55 Dr. [REDACTED] performing compressions at this time.  
 07:55 Assist ventilation with newborn Ambu bag  
 07:58 A chest X-ray performed at this time.  
 08:01 Assist ventilation with newborn Ambu bag.  
 08:04 Pt placed onto warm pillow case and blankets at this time to keep body temperature up.  
 08:07 Assist ventilation with newborn Ambu bag.  
 08:08 Pt being placed in a carrier to be transported via EMS to [REDACTED]  
 08:10 Pt's SAT at this time is 93%.  
 08:12 Pt moved back into room and placed on monitor at this time. [REDACTED] baby bus in route to this facility.  
 08:14 Blood pressure attempted at this time with no success.  
 08:18 Assist ventilation with newborn Ambu bag.  
 08:21 ET tube not in correctly. ET tube discontinued at this time.  
 08:22 Inserted intraosseous access 15mm in left tibial tuberosity.  
 08:23 Dr. [REDACTED] performing compressions at this time.  
 08:23 IO discontinued at this time.  
 08:23 Assist ventilation with newborn Ambu bag.  
 08:24 [REDACTED] attempting to intubate at this time.  
 08:25 Assisted provider with intubation with 4.0 mm ETT. via oral route. Assist ventilation with newborn Ambu bag. Intubated by [REDACTED] actual tube size was 3.0 and the CO2 detector not changing color.  
 08:26 Pt turned onto right side at this time per Dr. [REDACTED]  
 08:27 Suctioned, nasally, collected moderate amount of thick white substance consistent with formula Assist



**Tennessee Department of Children's Services**  
**Case Recording Summary**

Case Id: [REDACTED]

Case Name: [REDACTED]

Case Status: Close

Organization: [REDACTED] Region

ventilation with newborn Ambu bag.

08:28 [REDACTED] attempting to use the GlideScope to intubate pt with no success.  
 08:29 Suctioned, nasally, collected moderate amount of thick white substance consistent with formula.  
 08:30 [REDACTED] attempting to intubate pt with no success.  
 08:31 Compressions continuing at this time.  
 08:31 Assist ventilation with newborn Ambu bag.  
 08:33 [REDACTED] attempting to intubate with GlidScope at this time with no success.  
 08:35 Compressions continuing at this time.  
 08:35 Assist ventilation with newborn Ambu bag.  
 08:37 [REDACTED] RN is Primary Nurse.  
 08:37 Primary Nurse role handed off by [REDACTED], RN.  
 08:37 Assisted provider with intubation with 4.0 mm ETT. via oral route. Assist ventilation with newborn Ambu bag. Intubated by [REDACTED] actual size of tube 3.0 and the CO2 detector not changing color. The tube is at 2 on the line.  
 08:38 Assist ventilation with newborn Ambu bag.  
 08:40 [REDACTED] nurses and baby bus arriving at this time.  
 08:44 Pt now switched to [REDACTED] monitor at this time. No heart rate without compressions at this time. Compressions continuing.  
 08:47 Pt's heart rate 102 at this time. Compressions continuing.  
 08:50 [REDACTED] attempting to get foreign body out of throat at this time using forceps per the doctor with Children's orders. The forceps being to large for pt's mouth [REDACTED] was unable to retrieve foreign object.  
 08:58 Missed attempts: 22 gauge X 1 right femoral region. per [REDACTED]  
 08:59 Chest X-ray performed at this time.  
 09:00 ET tube pulled back slightly due to being to far down.  
 09:03 Pt's does not have a heart rate at this time with no compressions being performed. Compressions continuing.  
 09:03 Missed attempts: 22 gauge X 1 in left antecubital area, per [REDACTED] nurse.  
 09:06 Compressions continuing at this time.  
 09:07 Missed attempts: 22 gauge X 1 in right femoral. per [REDACTED]  
 09:11 Compressions continuing. Family in room to see pt.  
 09:11 Assist ventilation with newborn Ambu bag.  
 09:15 Pt has not heart rate without compressions and is not breathing on own. Compressions stopped and ambu bagging ending. Code has ended. Pt to be pronounced.  
 09:20 [REDACTED] MD is Pronouncing Provider.  
 09:46 RADIOLOGY DISK OF X-RAYS GIVEN TO ETCB TRANSPORT CREW ALONG WITH CHART. CONFIRMED WITH THEM THAT THE FULL CHART WILL BE FAXED TO [REDACTED].  
 11:53 Patient has correct armband on for positive identification. Bed in low position. Adult w/ patient. Cardiac monitor on. Patient placed on continuous pulse ox. NIBP on.

There is a list of administered medications with times and doses [REDACTED] was given epinephrine.

06:50 [REDACTED] RRT STARTED BLOW BY OXYGEN AT 6L. PATIENT CHANGED TO SIMPLE MASK AT 0701.  
 07:07 Assist ventilation with newborn Ambu bag.

**Outcome:**

07:31 Transferred by EMS ground Facility transferred. [REDACTED] to Pediatric facility Transfer form completed. Report called to [REDACTED], RN. Pain scale at disposition 0 / 10.  
 08:18 ER care complete, transfer ordered by MD.  
 09:15 Patient expired: Private MD notified.  
 09:31 Patient expired: ME notified.  
 09:45 Patient expired: Time of death 09:15 Pronounced by [REDACTED] MD.  
 11:37 Transferred  
 Patient expired: Body released to [REDACTED] Co Rescue Squad to transfer to [REDACTED] Forensics Scrubs.



**Tennessee Department of Children's Services**  
**Case Recording Summary**

Case Id: [REDACTED] Case Name: [REDACTED]  
Case Status: Close Organization: [REDACTED] Region

11:37 Patient expired: Body released for autopsy to Transported by [REDACTED] Rescue Squad.  
11:44 Patient expired: [REDACTED] notified. Pt was not qualified for services. Maternal Hep C.  
11:44 Patient expired: Body released to ME [REDACTED] forensic.  
11:51 Condition: expired  
11:52 Patient's phone number for contact Mother [REDACTED] - [REDACTED]  
12:37 Patient left the ED.

**Physician Documentation**

Arrival time was listed as 06:41 and date was 05/17/2015. The physician was Dr. [REDACTED]. The complaint was "not acting right." The patient presents to the emergency department with lethargic, not acting right. Onset: The symptoms/episode began/occurred this morning. Associated signs and symptoms: Pertinent positives: circumcision yesterday. Modifying factors: The patient symptoms are alleviated by nothing, the patient symptoms are aggravated by nothing. Treatment prior to arrival: none. The patient has not experienced similar symptoms in the past. The patient has not recently seen a physician. The code status was full code.

**ROS:**

07:38 Constitutional: Positive for malaise.  
07:40 Skin: Positive for bleeding around circumcision site, dried blood around penis. All other systems negative.

Exam completed at 07:42. Patient appears listless, pallor. [REDACTED] is sunken. Heart rate 130 bpm, regular rhythm, heart sounds difficult to auscultate. Severe respiratory distress noted. Labored breathing, grunting, decreased breath sounds that are moderate, scattered. Abdomen appears normal, bowel sounds normal, palpation: mild distension. Skin: pallor, cyanosis. Neuro is listless, minimally responsive.

**Procedures:**

09:14 intubation by anesthesia very difficult with multiple attempts, successful x 2, initial airway lost and replaced with GlideScope by anesthesia, visualized cords confirmed via cxray R mainstem repositioned by anesthesia.  
09:17 Performed Intraosseous line placed R tibia by anesthesia using standard technique.

**MDM:**

06:56 Patient medically screened.  
07:45 Differential diagnosis: viral infection, bacterial infection, URI, bronchitis, pneumonia UTI, gastroenteritis, meningitis, hypovolemia, shock, blood loss.  
Data reviewed: vital signs, lab test result (s), nurses notes, and as a result, I will transfer emergently to children's.  
Counseling: I had a detailed discussion with the patient and/or guardian regarding : the historical points, exam findings, and any diagnostic results supporting the discharge/admit diagnosis, lab results, the need to transfer to another facility.  
Physician consultation: discussed with Dr. [REDACTED] will accept in transfer, will send their transport team but if able to stabilize can sent via our EMS, anesthesia here assisting with IV access/difficult airway.  
08:18 Physician consultation: Dr. [REDACTED] patient PCP with patient in ED assuming care will travel with patient to [REDACTED] Children's.  
09:11 ED course: Extensive course in ED with anesthesia/D [REDACTED] [REDACTED] TN Children's at bedside see code sheet for full info, very difficult airway with initial airway lost then bradycardia necessitation PALS second airway established with glidscope by anesthesia, PALS continue for greater than 45 mins family at bedside code called again see nursing



## Tennessee Department of Children's Services

### Case Recording Summary

Case Id: [REDACTED]  
Case Status: Close

Case Name: [REDACTED]  
Organization: [REDACTED] Region

code sheet for full details.  
09:18

Special discussion: Additional tube visualized in esophagus with glidscope, tube not from anything placed in ED, no clear idea where tube from also seen on xray, family denies giving any meds or via syringe or other manner.

Child was given epinephrine. Patient pronounced on 2015/05/17 09:15:00 by [REDACTED] Impression: Acute Respiratory Distress/Insufficiency, Bradycardia, Cardiopulmonary Resuscitation. Released to Medical Examiner.

Initial report of death completed by [REDACTED] Hospital Association listed cardiopulmonary cessation as diagnosis/cause of death. Death certificate will be signed by Dr. [REDACTED] Full autopsy was ordered.

Report of investigation by county medical examiner listed probable cause of death as pediatric death. The manner of death was noted to be pending investigation. It was noted that there were multiple IV attempts and there was a tube-like apparatus, tracheo esophageal present on xray. Conduct before death was noted to be "efforts to obtain help." The narrative summary of circumstances surrounding death said said mother brought patient to ER with complaints of "not acting right." States was fine, woke at 4am to eat. Similac formula given <1oz. Didn't eat as much as usual. Became concerned by the sounds he was making and became pale. Upon arrival, patient pale, retracting, nasal flaring, (unable to decipher word) breathing. HR 135 O2 SAT 90%. Compressions began 0740, intermittently with multiple intubations. IO placement, [REDACTED] Dr. [REDACTED] Dr. [REDACTED] present. Code called 0915. HX: mother Hep C +, suboxone throughout pregnancy, circumcision 5/16/15 Dr. [REDACTED]

[REDACTED] newborn record from [REDACTED] Medical Center and medical records from [REDACTED] Family Medicine were included in the medical records.

Radiology report was included in the records received:  
EXAM(S):

Portable chest 05/17/2015

5 portable chest images were obtained first image 07:37 with no separate time designation of the separate images placed on the same order number. Images are numbered 1 -5 of 6

Image 1/6 wall demonstrates two tubes of similar caliber in the path of the esophagus with distal tip of one of the tubes at the gastroesophageal junction and the tip of the other tube below the carina 11 mm at the primal end of the tubes are not visualized. The lungs are clear and the heart mediastinum are within normal limits. No acute bony abnormality or pneumothorax. The thin bowel gas pattern has minimal increased bowel gas.

Image 2/6 demonstrates the two tubes to be in the same position, appearing to be in the esophagus with the proximal end of the higher tube extending out the oral cavity. The proximal and of the deeper tube is extending into the nasal cavity with the primal tip not visualized above the image. The lungs remain grossly clear with slight increased perihilar interstitial densities.

Image 3/6 one of the tubes has been pulled back with the tip at the thoracic inlet unable to different whether it is in the trachea or cervical esophagus on the single frontal projection. The deeper tube is unchanged in position with tip at the level of the gastroesophageal junction overlying the course of the esophagus. The lungs demonstrate increased inflation compared to the previous image and patchy perihilar interstitial densities persist but no lobar collapse or consolidation is evident.

Image 4/6 fully visualizes the extent of the deeper positioned tube with tip at the gastroesophageal junction in the course of the esophagus and the proximal tiup appearing to be in the nasal passageway to the anterior margin of the maxilla just above the hard palate. The second tube has been pulled back and the tip is in the posterior oropharynx entering the coursing through the oral cavity. The lungs remain grossly clear minimal prominence of the perihilar interstitial densities.

Image 5/6 demonstrates a orotracheal tube with tip in the right mainstem bronchus. The second tube appearing of several large caliber and length extends from the nasal passageway to the gastroesophageal junction and the course of the esophagus. The lungs demonstrate poorer inspiration with increased hazy interstitial perihilar densities and



**Tennessee Department of Children's Services**  
**Case Recording Summary**

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Case Id: [REDACTED]

Case Name: [REDACTED]

Case Status: Close

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subtle volume loss in the leg lung. There is no 6/6 image.

The progress note completed by Dr [REDACTED] and entered into case recordings previously was in the medical records received.



**Tennessee Department of Children's Services**  
**Case Recording Summary**

Case Id: [REDACTED]	Case Name: [REDACTED]
Case Status: Close	Organization: [REDACTED] Region

**Case Recording Details**

Recording ID: [REDACTED]	Status: Completed
Contact Date: 05/20/2015	Contact Method:
Contact Time: 08:20 PM	Contact Duration: Less than 05
Entered By: [REDACTED]	Recorded For:
Location:	Created Date: 05/26/2015
Completed date: 06/19/2015	Completed By: [REDACTED]
Purpose(s): Permanency, Safety - Child/Community, Service Planning, Well Being	
Contact Type(s): Notation	
Contact Sub Type:	

**Children Concerning****Participant(s)****Narrative Details**

Narrative Type: Original      Entry Date/Time: 05/26/2015 01:21 PM      Entered By: [REDACTED]

05/20/2015

CPSI submitted the completed form CS-0635, Notice of Child Death/Preliminary Near Death, to [REDACTED], Regional Investigative Coordinator [REDACTED], Investigative Coordinator [REDACTED], Lead Investigator [REDACTED] and Regional General Counsel [REDACTED] via email on this date.

The completed form has been scanned into the documents portion of this investigation.



**Tennessee Department of Children's Services**  
**Case Recording Summary**

Case Id: [REDACTED]	Case Name: [REDACTED]
Case Status: Close	Organization: [REDACTED] Region

**Case Recording Details**

Recording ID: [REDACTED]	Status: Completed
Contact Date: 05/20/2015	Contact Method: Face To Face
Contact Time: 04:45 PM	Contact Duration: Less than 02 Hour
Entered By: [REDACTED]	Recorded For:
Location: DCS Office	Created Date: 05/26/2015
Completed date: 06/19/2015	Completed By: [REDACTED]
Purpose(s): Permanency,Safety - Child/Community,Service Planning,Well Being	
Contact Type(s): Alleged Perpetrator Interview,Parent/Caretaker Interview	
Contact Sub Type:	

**Children Concerning****Participant(s)****Narrative Details**

Narrative Type: Original      Entry Date/Time: 05/26/2015 11:57 AM      Entered By: [REDACTED]

05/20/2015

4:45 PM

Type of Contact: F2F with parents/alleged perpetrators

Location: [REDACTED] County DCS Office

Present: [REDACTED] [REDACTED]

[REDACTED] and [REDACTED] arrived at the DCS Office in [REDACTED] County at approximately 4:45 PM on this date.

CPSI and Detective [REDACTED] first spoke with [REDACTED] while [REDACTED] waited in the lobby of the office. CPSI had gathered information from [REDACTED] previously during initial contact in the open investigation. CPSI had also completed the appropriate initial paperwork with [REDACTED] while at the hospital on 05/12/2015.

[REDACTED] reported that [REDACTED] was started on Similac Advance formula at the hospital. She believed it was on Monday night because that night [REDACTED] was fussy and was crying. They switched him to Similac Sensitive after that. They were using the small pre-made bottles of formula. The hospital could not send that formula home with her, but she was able to take the remaining bottles of the formula that were in the hospital room. The hospital sent a large bottle of liquid Similac Advance home with them. She thought she would have enough of the sensitive type until her WIC appointment on Monday. [REDACTED] reported she stopped breastfeeding on Tuesday. [REDACTED] said the Similac Sensitive lasted until Saturday night/Sunday morning at 12am. She said she opened the bottle of Similac Advance on Sunday morning about 2:00am. She said [REDACTED] ate about 2oz. She said it was not quite a full 2oz. She said he woke back up around 4am on Sunday morning. She said he had about an ounce at that time and went back to sleep. She said she got up around 6am. She said [REDACTED] was crying and making a grunting sound. She said [REDACTED] eyes were reactive but his body was not. She said when she went to change his diaper and dressing from the circumcision, she noticed that his legs were white. She said she called Dr. [REDACTED] pediatrician, and was advised to go to the emergency room. [REDACTED] said the doctors worked on [REDACTED] for about two hours. She said she was told they did everything.

[REDACTED] reported [REDACTED] was typically eating about two ounces of formula every three to four hours. She said he spit up maybe twice in total. She said his spit up was normal infant spit up. She said there were no issues with [REDACTED] at



## Tennessee Department of Children's Services

## Case Recording Summary

Case Id: [REDACTED]

Case Name: [REDACTED]

Case Status: Close

Organization: [REDACTED] Region

the doctor's office on Friday. She said he was circumcised on Saturday by Dr [REDACTED]. [REDACTED] said they had been monitoring [REDACTED] for withdrawal symptoms as advised by [REDACTED] Medical Center. She named the symptoms as tremors, shaking, and fussiness. [REDACTED] said [REDACTED] had not exhibited any signs.

[REDACTED] reported [REDACTED] seemed fine at 4am. She said the only "weird" thing is he only wanted one ounce. She did not think much about that since he had about two ounces only two hours earlier. [REDACTED] denied any changes in [REDACTED] behaviors, feeding, bowel movements, etc.

[REDACTED] reported that on the night of Saturday the 16th, she, the father and [REDACTED] slept in the same bed. She explained that the father [REDACTED] was asleep on the side of the bed closest to the door, she slept on the end of the bed perpendicular to the father, and [REDACTED] slept in the right corner of the bed. She reported [REDACTED] was wearing a diaper, socks, and a complete onsie with feet. She said he was also swaddled. She reported [REDACTED] liked to be swaddled tightly and she had the nurses at the hospital instruct her on how to swaddle him. She denied they used any blankets on the bed that night.

[REDACTED] reported that when she woke up Sunday morning around 6am [REDACTED] was awake and was talking to [REDACTED]. CPSI did ask [REDACTED] if there was any way she or [REDACTED] could have rolled over onto the infant at some point. [REDACTED] said no. She said that when she woke up, [REDACTED] had to stretch his arm completely to even touch [REDACTED]. [REDACTED] reported this was the first night they had all slept together in the same bed. She said she went to make [REDACTED] a bottle. She said she got the bottle but noticed that [REDACTED] was making an odd sound. She described the sound as a grunting type sound or "uh, uh, uh." She said it was like he could not catch his breath. [REDACTED] said she tried to soothe [REDACTED] by giving him a passie. [REDACTED] said she took [REDACTED] to her grandmother [REDACTED] because of her concerns.

[REDACTED] reported it was about five minutes between the time she woke up and the time she called the doctor. She said it was about another ten minutes before they left the house because they were trying to gather everything. She said it took them about ten minutes to get from the house to the hospital in [REDACTED].

[REDACTED] said everything had been normal with [REDACTED]. She said his poop was normal, a peanut butter consistency, green and brown in color. She had not had any concerns about [REDACTED] breathing, feeding, or anything up until Sunday morning.

[REDACTED] reported that when they got to the emergency room, she told the staff that something was wrong with [REDACTED]. They listened to [REDACTED] and then took them back. [REDACTED] said she held [REDACTED] in the car on the way to the hospital. She said he continued making the sound like he couldn't breathe. She said it was like he was having a panic attack.

[REDACTED] reported that when she had woken up around 4am [REDACTED] had peed and she changed his diaper. He drank the bottle until he got down to about an ounce. She said [REDACTED] looked sleepy and kept going to sleep so she stopped. She denied that he had spit up. CPSI asked [REDACTED] if she noticed any spit up or other fluids on [REDACTED] when she woke up around 6am. [REDACTED] said she didn't look.

[REDACTED] was asked if anyone in the home had any serious medical issues that would involve the use of medical devices such as a catheter. [REDACTED] said no. [REDACTED] was asked if [REDACTED] had been given any medication. [REDACTED] said no. She said she was told she could give [REDACTED] liquid Tylenol for infants but she had the wrong syringe. She said she never opened the bottle. The unopened bottle and syringe had been observed in the diaper bag. [REDACTED] also denied giving [REDACTED] any gas drops or other medication or supplements.

[REDACTED] was asked how she fed [REDACTED]. [REDACTED] said she always sat up and fed him. She said she fed [REDACTED] that night and that morning, not [REDACTED]. She said she only breastfed for a couple of days in the hospital and had not breastfed since leaving the hospital.

[REDACTED] was asked about children being around [REDACTED]. She said her four year old nephew was around [REDACTED] but they were never alone. [REDACTED] was in his swing. That was Friday evening. This question was asked due to the concern of a foreign object being found in [REDACTED] esophagus.

[REDACTED] was asked if there were any complications or problems with [REDACTED] at [REDACTED] Medical Center. [REDACTED] said it was a quick birth which caused [REDACTED] to have a bruise around his mouth and some blood vessels busted. She said [REDACTED]



## Tennessee Department of Children's Services

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Case Name: [REDACTED]

Case Status: Close

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was full of mucus the first day as well as a result of the quick birth. She said [REDACTED] did not have time to get rid of all of the mucus and liquid. She said [REDACTED] did not eat a lot that first day. She said they had to suction [REDACTED] for the first 24 hours. She explained that the suctioning was completed with a bulb and nothing else. [REDACTED] was asked if she could think of anything else that was odd or not normal. She said [REDACTED] sneezed a lot and would sneeze over and over. She said he did that at the hospital and at home. She said she did not think much of it because [REDACTED] did that, too. [REDACTED] denied knowledge of [REDACTED] having anything placed down his throat at [REDACTED] Medical Center.

[REDACTED] was asked about the events at [REDACTED] Hospital. [REDACTED] said they got there, told the staff something was wrong with her baby, and they looked at him. She said they were taken back. She said they opened [REDACTED] diaper and then she had to leave. She said her and [REDACTED] went outside. She said they would not let them in the room. She said she first saw that they had a thing over [REDACTED] face making him breathe. She said they were trying to get an IV. [REDACTED] said they really didn't tell her anything. She said one of the nurses told her at some point that they were trying to put a tube down [REDACTED] throat. She asked if [REDACTED] couldn't breathe. She said she was told that [REDACTED] was just having some trouble. [REDACTED] said then she heard Radiology paged to Room 4 "stat" and that was [REDACTED] room. She said they got an IV in. She said [REDACTED] said she was told [REDACTED] had stopped breathing and his heart had stopped beating and then the hospital worked on him for two hours. [REDACTED] said the second time she went back to the room, she saw a tube in [REDACTED] mouth and they were doing chest compressions. She said Dr. [REDACTED] came out and asked her and [REDACTED] if she or anyone had put something in [REDACTED] mouth because it looked like something was blocking his airway. She said she was told that they put a tube in and formula came up. She said the only things that had been put in [REDACTED] mouth were a passie and a bottle.

[REDACTED] was asked about the sleeping situation. She said [REDACTED] had been sleeping in the bed with her. She said they had a fan on in the room on Saturday night into Sunday morning. She said there were other times after he came home that she had a heater on in the room because it would get cold at night. She said she would set the heater at seventy degrees. She said Saturday night was the first night they had the fan on in the room. She said it was a table fan that sat on the chest of drawers in the room. She said the window was closed. She could not think of any other changes. She was asked if [REDACTED] seemed sweaty or anything Sunday morning and [REDACTED] said no. She said one night he was sweaty and she turned the heater off that night.

[REDACTED] demonstrated how she swaddled [REDACTED]. The square receiving blanket was positioned with the corners at the top, bottom, and sides. The top corner was folded down. The bottom corner was pulled up and placed on [REDACTED]. One corner was pulled over and tucked under [REDACTED]. The other corner was pulled over and tucked under. His hands were kept in the swaddle. She said [REDACTED] liked a really tight swaddle. She said he was swaddled the same way every time. She said she swaddled him the same way at home as he was at [REDACTED] Medical Center.

CPSI told [REDACTED] she would like to follow up in a week or two to check on her and [REDACTED]. [REDACTED] asked why. CPSI told [REDACTED] it was because she cared about the families she worked with and wanted to follow up with her and her family about services. CPSI informed [REDACTED] that a referral had been made to the New Beginnings program with [REDACTED] and she had spoken with a worker from the program. CPSI told [REDACTED] she was still able to participate in that program. CPSI talked to [REDACTED] about the need for continued services and trying to regain custody of her oldest child [REDACTED].

CPSI and Detective [REDACTED] then spoke with [REDACTED]. [REDACTED] told CPSI on the way to the conference room that the interview would probably be short. It did not appear that [REDACTED] wanted to be there or answer questions. CPSI did thank [REDACTED] for coming in. [REDACTED] was interviewed alone and in private with Detective [REDACTED].

[REDACTED] denied observing any changes in [REDACTED] behaviors, eating, sleeping, bowel movements, etc. He said [REDACTED] didn't really spit up and burped fine. He said [REDACTED] typically had a bottle every two and a half to three hours.

[REDACTED] reported they went to bed on Saturday night the 16th around 10:30 or 11pm. [REDACTED] explained that he, [REDACTED], and [REDACTED] were sleeping in the same bed that night. He explained that he slept on the left side of the bed, [REDACTED] was lying on his back in the middle of the bed, and [REDACTED] slept on the other side of the bed closest to the wall. He was not sure exactly what time [REDACTED] got up. He said it was 12:30, 1, or 2am. [REDACTED] fixed a bottle for [REDACTED]. [REDACTED] said they both participated in Feeding [REDACTED] at that time. He said [REDACTED] sat up and fed [REDACTED]. He said that when he fed [REDACTED] [REDACTED] was lying down and he held the bottle for a few minutes. He said he sat the bottle down [REDACTED] said he was not sure when [REDACTED] woke up next because he did not wake up that time. He said [REDACTED] woke up with



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### Case Recording Summary

Case Id: [REDACTED]

Case Name: [REDACTED]

Case Status: Close

Organization: [REDACTED] Region

[REDACTED] That would have been the reported 4am feeding time. [REDACTED] said he did not remember when he woke up. From [REDACTED] statements, it is believed it was around 6am [REDACTED] said [REDACTED] was "breathing funny." He said it was like [REDACTED] was in pain or something. He said the sound was like a half cry or he was short of breath.

[REDACTED] said he did not think the window was open that night. He could not remember if there was a fan or not. He denied that [REDACTED] was sweaty or anything when he woke up that morning. He said he did not know what [REDACTED] was wearing. He said [REDACTED] was wrapped in a blanket "like a burrito." He said again the sound was like a half-cry or he was short of breath.

[REDACTED] said that when they got to the emergency room, the nurse initially reported that [REDACTED] was breathing okay. He said then a couple of hours passed and he died.

[REDACTED] reported he did not know what happened. He said [REDACTED] was a good baby. He said [REDACTED] would only whimper if his diaper needed to be changed or he wanted to eat. He said [REDACTED] was fine the night before on the 16th. He could not think of anything out of the ordinary with [REDACTED]

[REDACTED] was asked again about the sleeping arrangement. He said [REDACTED] was lying between him and [REDACTED]. He said there was at least a foot and a half of space on either side of [REDACTED] and between them.

CPSI then began talking to [REDACTED] about available services. [REDACTED] wanted to leave and was allowed to leave.

CPSI walked [REDACTED] and [REDACTED] out of the office and thanked them for speaking with her and Detective [REDACTED]

Worker Observations: Neither parent appeared scared or nervous during the interviews. They appeared upset. [REDACTED] cried several times [REDACTED] was not talkative and it did not appear that he wanted to speak with CPSI and Detective [REDACTED]



**Tennessee Department of Children's Services**  
**Case Recording Summary**

Case Id: [REDACTED]	Case Name: [REDACTED]
Case Status: Close	Organization: [REDACTED] Region

**Case Recording Details**

Recording ID: [REDACTED]	Status: Completed
Contact Date: 05/20/2015	Contact Method: Phone Call
Contact Time: 03:15 PM	Contact Duration: Less than 05
Entered By: [REDACTED]	Recorded For:
Location:	Created Date: 05/21/2015
Completed date: 05/22/2015	Completed By: [REDACTED]
Purpose(s): Permanency,Safety - Child/Community,Service Planning,Well Being	
Contact Type(s): Collateral Contact	
Contact Sub Type:	

**Children Concerning****Participant(s)****Narrative Details**

Narrative Type: Original      Entry Date/Time: 05/21/2015 01:20 PM      Entered By: [REDACTED]

5/20/2015  
3:15 PM

TC [REDACTED] social worker at [REDACTED] Medical Center

CPSI contacted [REDACTED] with [REDACTED] Medical Center. [REDACTED] was the social worker assigned to the child while he was in the hospital. CPSI asked [REDACTED] if there were any medical issues with [REDACTED] while he was in the hospital. [REDACTED] said no. CPSI asked if the child was intubated at any time during his stay at the hospital. [REDACTED] said no. She said he would not have been intubated unless he was transferred to an emergency room or the neonatal intensive care unit. She said he was not transferred to the intensive care unit while at the hospital. She denied that there had been any tubes placed in the child or that he was intubated.

[REDACTED] called CPSI shortly after the previous conversation had ended. She reported that the meconium drug test results had been received. She said [REDACTED] meconium was positive for Suboxone and marijuana. [REDACTED] did fax the results along with some additional medical information to CPSI on this date. Those documents will be scanned into the documents portion of this investigation.



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**Case Recording Summary**

Case Id: [REDACTED]	Case Name: [REDACTED]
Case Status: Close	Organization: [REDACTED] Region

**Case Recording Details**

Recording ID: [REDACTED]	Status: Completed
Contact Date: 05/20/2015	Contact Method: Correspondence
Contact Time: 02:00 PM	Contact Duration: Less than 15
Entered By: [REDACTED]	Recorded For:
Location:	Created Date: 05/22/2015
Completed date: 06/19/2015	Completed By: [REDACTED]
Purpose(s): Permanency, Safety - Child/Community, Service Planning, Well Being	
Contact Type(s): Collateral Contact	
Contact Sub Type:	

**Children Concerning****Participant(s)****Narrative Details**

Narrative Type: Original      Entry Date/Time: 05/22/2015 02:04 PM      Entered By: [REDACTED]

05/20/2015

CPSI met with Detective [REDACTED] about this case.

Detective [REDACTED] provided CPSI with a copy of the provisional autopsy report received from the Regional Forensic Center in [REDACTED] County.

Cause of Death: Pending

**Provisional Anatomic Diagnosis**

- I. Pending toxicology
- II. Pending microscopic examination
- III. Pending cultures
- IV. Pending neuropathologic examination
- V. Presence of endotracheal tube in oropharynx, esophagus, and stomach
  - a. Clinical history of endotracheal intubation impeded by tube-like foreign object in back of throat
  - b. History of male neonate making funny noises and having poor feeding prior to death
  - c. Pending further investigation

Comment: These are preliminary findings only. After additional testing is complete, there may be revision of these findings and addition of other findings. These changes will be reflected in the final report.

This was completed and signed by Dr. [REDACTED].

Detective [REDACTED] spoke with the medical examiner's office, the Forensic Center, and Dr. [REDACTED] on this date. The medical examiner's office reported the object found in the child's throat was not medical and they did not know what it was. They said the object was not from their facility. The Forensic Center reported the object found in the child's throat was an ET tube (endotracheal tube). They said they did not know where the tube came from. He left a message for Dr. [REDACTED]. Dr. [REDACTED] called him back later. He reported the tube was located in the child's esophagus and into the stomach. He reported there was milk/formula below the tube, above the tube, and clogged in the tube. He reported the tube found in the infant could be a contributing factor in the infant's death. Detective [REDACTED] inquired



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Case Id: [REDACTED]

Case Name: [REDACTED]

Case Status: Close

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about the possibility of withdrawal symptoms being a contributing factor in the infant's distress or death. Dr. [REDACTED] reported he did not believe so as signs of withdrawal usually arose within approximately 24 hours.

05/20/2015

[REDACTED] medical records were received from [REDACTED] and [REDACTED] on this date. [REDACTED] received prenatal care from that center. She began prenatal care in December 2014. There was a gap in care from January to March 2014. She was positive for Suboxone and marijuana during prenatal care. The records have been scanned into the documents portion of this investigation.



**Tennessee Department of Children's Services**  
**Case Recording Summary**

Case Id: [REDACTED]	Case Name: [REDACTED]
Case Status: Close	Organization: [REDACTED] Region

**Case Recording Details**

Recording ID: [REDACTED]	Status: Completed
Contact Date: 05/20/2015	Contact Method:
Contact Time: 02:00 PM	Contact Duration: Less than 05
Entered By: [REDACTED]	Recorded For:
Location:	Created Date: 05/26/2015
Completed date: 05/26/2015	Completed By: [REDACTED]
Purpose(s): Service Planning	
Contact Type(s): Notation	
Contact Sub Type:	

**Children Concerning****Participant(s)****Narrative Details**

Narrative Type: Original      Entry Date/Time: 05/26/2015 12:02 PM      Entered By: [REDACTED]

05/20/2015

[REDACTED] and [REDACTED] did not show up to the DCS office at 2pm as scheduled. CPSI contacted them at 2:21 PM and spoke with [REDACTED]. [REDACTED] said he was not sure if they would be able to make it to the office. Detective [REDACTED] asked to speak with [REDACTED] and he did [REDACTED] agreed that he and [REDACTED] could meet later on this date around 6:30 or 7:00 PM.

5/20/2015

CPSI received a phone call from [REDACTED] at 4:22 PM. She said they were home and settled and could meet earlier if CPSI was free. She said they could be at the office in ten to fifteen minutes.



**Tennessee Department of Children's Services  
Case Recording Summary**

Case Id: [REDACTED]  
Case Status: Close

Case Name: [REDACTED]  
Organization: [REDACTED] Region

**Case Recording Details**

Recording ID:	[REDACTED]	Status:	System Completed
Contact Date:	05/19/2015	Contact Method:	Face To Face
Contact Time:	04:45 PM	Contact Duration:	Less than 02 Hour
Entered By:	[REDACTED]	Recorded For:	
Location:	Family Home	Created Date:	05/22/2015
Completed date:	06/19/2015	Completed By:	System Completed
Purpose(s):	Permanency,Safety - Child/Community,Service Planning,Well Being		
Contact Type(s):	Collateral Contact,Other Persons Living in Home Interview/Observation,Sibling Interview/Observation		
Contact Sub Type:			

**Children Concerning**

**Participant(s)**

[REDACTED]

**Narrative Details**

Narrative Type: Original      Entry Date/Time: 05/22/2015 10:29 AM      Entered By: [REDACTED]  
 5/19/2015  
 4:45 PM  
 Type of Contact: Initial F2F with the family  
 Location: Family Home; [REDACTED]  
 Present: Maternal Grandmother [REDACTED], Maternal Great-Grandmother [REDACTED], other household member [REDACTED]  
 Not Present: [REDACTED]

**Household Composition:**

[REDACTED] DOB [REDACTED] SSN [REDACTED] (mother, alleged perpetrator)  
 [REDACTED] DOB [REDACTED] (father, alleged perpetrator)  
 [REDACTED] DOB [REDACTED] SSN [REDACTED] (maternal grandmother)  
 [REDACTED] DOB [REDACTED] SSN [REDACTED] (household member)  
 [REDACTED] DOB [REDACTED] SSN [REDACTED] (maternal great-grandmother)

CPSI [REDACTED] and Detective [REDACTED] completed an unannounced visit to the family home located at [REDACTED] TN. CPSI and Detective [REDACTED] were greeted outside by the maternal grandmother and introduced themselves. Present at the time of the visit were the maternal grandmother [REDACTED], the maternal great-grandmother [REDACTED], other household member [REDACTED] and child [REDACTED]. [REDACTED] recognized CPSI from a visit to her home the week before and said hello. CPSI and Detective [REDACTED] explained the purpose of the visit to the home. CPSI and Detective [REDACTED] were informed that the parents [REDACTED] and [REDACTED] were not present at the home at that time, their exact location was unknown, and it was unknown when they would return. CPSI asked to speak with the individuals alone and in private. CPSI and Detective [REDACTED] spoke first with the maternal grandmother [REDACTED]. She chose to



**Tennessee Department of Children's Services**  
**Case Recording Summary**

Case Id: [REDACTED]  
 Case Status: Close

Case Name: [REDACTED]  
 Organization: [REDACTED] Region

speak outside on the front porch while the two other household members and the child remained inside the home. [REDACTED] reported she has resided in the home for approximately three years. She reported the home is made up of her, her mother [REDACTED], and family friend [REDACTED]. They rent the home from [REDACTED] and [REDACTED]. She reported the infant's parents [REDACTED] and [REDACTED] live in the home off and on. [REDACTED] said [REDACTED] was not her boyfriend. She said he was a friend that helped take care of her.

CPSI asked [REDACTED] for a timeline of events beginning the day of discharge from the birth hospital, [REDACTED] Medical Center. [REDACTED] said she did not know what they did that day. She said she remembered she cleaned the home, cleaned out the ashtrays, and did stuff around the house to prepare for the baby to arrive. She said she thought it was still light out when the baby got home that night. She said she did not notice anything different about [REDACTED] between seeing him in the hospital and seeing him at home. She talked about how [REDACTED] would try to hold his head up and would stretch like a normal baby. She reported [REDACTED] was taking Similiac Gentle in the plastic bottles. She reported [REDACTED] was fed every two and a half to three hours; it was no longer than every four hours.

CPSI asked about Thursday. [REDACTED] said they got up, ate breakfast, and played with [REDACTED]. She said he liked his swing. She did not notice anything odd about his behaviors. She said [REDACTED] was burped after every 10 units of the bottle. She said there were no issues getting him to burp. She denied issues with feedings, bowel movements, or urine output. She said she thought they took [REDACTED] to a family member's home nearby to visit. She said she believed there was also a visit with the paternal grandmother [REDACTED]. She said [REDACTED] slept in his crib or bassinet Wednesday and Thursday nights. She said the bassinet was in [REDACTED] and [REDACTED] room. She said there were times she would observe [REDACTED] lying in between [REDACTED] and [REDACTED] and they were playing with him. She said they did not sleep like that. She said [REDACTED] was swaddled while lying there.

[REDACTED] said that when [REDACTED] was fed, it was like he was starving. [REDACTED] did not want to feed him too much but he just seemed hungry. [REDACTED] reported that they ran out of the Similiac Gentle on Saturday night and they had to use another type. She explained it was in a white bottle. [REDACTED] reported that [REDACTED] initially breastfed [REDACTED] in the hospital but stopped when she was told that both she and [REDACTED] were Hepatitis C positive. [REDACTED] would have had to be tested again several months later. [REDACTED] reported [REDACTED] was always concerned about [REDACTED] and called everyone to make sure she was doing everything right. She said [REDACTED] really wanted a son.

[REDACTED] could not remember what the family did on Friday. [REDACTED] reported that on Saturday, [REDACTED] was seen by his doctor, Dr. [REDACTED] for his circumcision. She said she thought that was mid-morning. She said after they got back, [REDACTED] was quieter but they were told that was normal. She said he slept a lot that day but woke up to eat. She said that after the circumcision, it seemed like [REDACTED] was bleeding a lot. She said they called the doctor and were told that was normal. [REDACTED] reported she went to bed early on Saturday, around dusk or 8:30, due to a migraine. She said she did not feed [REDACTED] Saturday night. She was asked about everyone that was around [REDACTED] Saturday. [REDACTED] said it was her, her mom, [REDACTED], her brother [REDACTED], and she thought [REDACTED] son [REDACTED] was there. She said [REDACTED] is about three years old. She denied that the child was ever alone with the infant.

[REDACTED] was asked about any complications with the birth. She said the birth was quick. She said the infant was kept at the hospital longer than usual because of that. She said they were worried because [REDACTED] initially did not cry. She was asked if she could think of anything unusual about [REDACTED] behaviors, eating, etc. She denied that. She said [REDACTED] was a normal baby. She said she was told that on Sunday morning, [REDACTED] was not breathing right. She said when she woke up Sunday morning, everyone was gone. She did not see or hear [REDACTED] that morning.

CPSI asked [REDACTED] if she ever had concerns about the parents [REDACTED] and [REDACTED]. [REDACTED] said no. She said [REDACTED] had miscarriages in the past and was so happy to have a son.

CPSI and [REDACTED] discussed grief counseling. [REDACTED] reported she already receives services with [REDACTED] Mental Health in [REDACTED] and has been given resources for additional services. CPSI provided her card to [REDACTED] and encouraged [REDACTED] to contact her if she needed any additional resources or services. [REDACTED] did spend some time talking about her medical issues. She also spent time providing memories of [REDACTED]. She reported [REDACTED] friend [REDACTED] came in and stripped the room of all of [REDACTED] things. She said all of the baby items were in his room with the curtains closed. She explained that [REDACTED] and [REDACTED] room was on the right side of the home and [REDACTED] room was on the left side. She said [REDACTED] had not slept in his room.



## Tennessee Department of Children's Services

## Case Recording Summary

Case Id: [REDACTED]

Case Name: [REDACTED]

Case Status: Close

Organization: [REDACTED] Region

CPSI and Detective [REDACTED] then spoke with [REDACTED] who had come outside to check on [REDACTED]. [REDACTED] went into the home so [REDACTED] could be spoken with alone and in private. [REDACTED] provided her date of birth and social security number. [REDACTED] reported she did visit with [REDACTED] while he was at [REDACTED] Medical Center after his birth. She said she was the one that drove up to the hospital on Wednesday and drove the family home. She said [REDACTED] died on Sunday. [REDACTED] denied having any concerns about [REDACTED] after his discharge from the hospital. She denied there were any issues.

CPSI asked [REDACTED] for a timeline of events. [REDACTED] reported they got home Wednesday afternoon or evening. She said [REDACTED] ate good and burped. She said he was fine. She reported his eating, burping, bowel movements, and urine output were fine. She reported that [REDACTED] started taking formula at [REDACTED] Medical Center. She said the first formula they tried [REDACTED] did not look and so they changed it. She said it was the same brand of formula but he liked the sensitive kind better. She said they were sent home with that formula from the hospital. She said she did not believe WIC would cover the formula that [REDACTED] seemed to like more. She said [REDACTED] took all of the sensitive formula they had at the home. She said [REDACTED] was started on the other formula on Sunday morning that he was initially given. It was later discovered that when [REDACTED] began taking formula, he was given Similac Advance. They switched him to Similac Gentle. He started taking the Similac Advance again Sunday morning after they ran out of the gentle type.

[REDACTED] could not think of anything out of the ordinary that took place last week. She initially could not remember what they did on Friday. She said on Saturday, [REDACTED] was circumcised. She said [REDACTED] wanted to do it the biblical way. She said Dr. [REDACTED] completed the circumcision. She said [REDACTED] was fine on Saturday. She said Dr. [REDACTED] played with him and so did Dr. [REDACTED] daughter. She thought the daughter was 15 or 16. [REDACTED] said after that, they went to see a friend [REDACTED]. They wanted [REDACTED] to see his great-grandfather but he was sick so they could not. She said they sat outside with the friend for twenty or thirty minutes, left, and came back home. She said she thought it was around noon when they got back home. She said [REDACTED] was fine. CPSI asked [REDACTED] about how often [REDACTED] was fed. [REDACTED] said it was about every three hours. She reported [REDACTED] was eating well. She said [REDACTED] always acted hungry. She said [REDACTED] was worried she was going to feed [REDACTED] too much. She said [REDACTED] was worried on Saturday about [REDACTED] circumcision bleeding.

[REDACTED] reported that on Sunday morning she was asleep. She said [REDACTED] brought [REDACTED] to her and said something was wrong. [REDACTED] said she told [REDACTED] to call Dr. [REDACTED]. [REDACTED] said [REDACTED] appeared white and was cold. She explained she put a cap on [REDACTED] head, put a blanket around him, and held him to her body to keep him warm. She said they had Dr. [REDACTED] on the phone and she heard the sound [REDACTED] was making. She said [REDACTED] was in the kitchen walking around when that was happening. [REDACTED] was asked about the noise. [REDACTED] said it was like [REDACTED] was straining to have a bowel movement but was having a hard time breathing. She said it was so strange. [REDACTED] said she thought [REDACTED] had ate about an hour before she was woken up. She said she did not know. She said she thought it was dark when [REDACTED] woke her up. [REDACTED] was asked about how [REDACTED] was fed. She said he was never laid flat to eat. She said he was held up with his head elevated. [REDACTED] said the only thing she could think of that changed with [REDACTED] was his formula on Sunday morning. She said she was not sure where the formula was now. She said she thought someone bagged up the formula and took it to get tested.

[REDACTED] was asked again about [REDACTED] behaviors. She denied any concerns. [REDACTED] was asked about [REDACTED] and [REDACTED]. [REDACTED] denied any concerns. She said she was so proud of [REDACTED]. She said she had been worried about [REDACTED] for a while in the past, but she was doing so much better. [REDACTED] said that after they left the hospital Sunday, [REDACTED] laid down in the back and [REDACTED] laid the front passenger seat back. They held each other. She said [REDACTED] was working a lot. When he got home, he would spend time with [REDACTED]. He said they would just lay there and stare into each other's eyes.

[REDACTED] was asked to name everyone that saw [REDACTED] on Saturday. She said [REDACTED] was around her [REDACTED] Dr. [REDACTED] her daughter, [REDACTED], [REDACTED] her son, [REDACTED] his wife [REDACTED] and their child [REDACTED]. [REDACTED] had come outside while [REDACTED] was providing the names of everyone that saw [REDACTED] on Saturday. She added that family friend [REDACTED] had come over that day. She said [REDACTED] did not hold or touch [REDACTED]. [REDACTED] reported she went to bed around 12:30 or 12:45 am that night.

CPSI asked [REDACTED] again if she could think of anything that had changed about [REDACTED]. [REDACTED] spoke up and said [REDACTED] had some diarrhea at the hospital when his formula was changed. It was reported that [REDACTED] was worried about [REDACTED] sleeping so much on Saturday. [REDACTED] said [REDACTED] told her she woke up a little after 2am, fed [REDACTED]



**Tennessee Department of Children's Services**  
**Case Recording Summary**

Case Id: [REDACTED]

Case Name: [REDACTED]

Case Status: Close

Organization: [REDACTED] Region

put him to bed, and then woke up again about 4:15 or 4:25am. [REDACTED] was fed, went back to sleep, and then woke up around 5:30am. She said [REDACTED] said [REDACTED] was cold and white so they called the doctor.

[REDACTED] and [REDACTED] were not able to say if [REDACTED] slept in his swing or bassinet in the room with [REDACTED] and [REDACTED] on Saturday night. Both denied having any concerns or seeing any issues with [REDACTED] on Saturday night.

[REDACTED] when on to talk about her religious beliefs, how she had encouraged [REDACTED] and [REDACTED] on Sunday, and a song she has been listening to, to help her cope.

CPSI was given permission to enter the home. [REDACTED] and [REDACTED] walked CPSI through the home. CPSI took pictures of the home. The front door leads to the living room. Immediately to the left is [REDACTED] room. [REDACTED] identified the corner of the living room where [REDACTED] swing was kept. After walking straight from the door and through the living room, you enter the kitchen. Immediately to the right is [REDACTED] and [REDACTED] room. The door was closed to the room. CPSI was allowed to enter the room to take pictures. There is a bed to the left of the door. [REDACTED] identified where [REDACTED] bassinet was placed in the room. It was in the middle of the room between the bed and a table. Prescription medication bottles were observed on a table in the room. [REDACTED] was prescribed Ibuprofen 800mg, fluoxetine, and nipple cream from [REDACTED] Medical Center. Across the hall and to the left of the kitchen was a room identified as [REDACTED] room. There were two cradles described as bassinets, a cradle swing, and a bouncy seat. The family had moved all of the infant's belongings into the room and out of the other rooms of the house. The family had clothing, diapers, wipes, and other necessities for the infant. [REDACTED] reported that [REDACTED] either slept in one of the cradles or the cradle swing. At the back of the home past the kitchen, [REDACTED] sleeps in back hallway area. It was reported [REDACTED] was only residing in the home until her home could be repaired. [REDACTED] reportedly sleeps in the living room.

After Detective [REDACTED] was given consent to search the home, he entered to take pictures. CPSI completed another walkthrough with Detective [REDACTED] and the family. While in [REDACTED] room, a bottle with formula in it was found. [REDACTED] said she was not aware of when that bottle was made. Attempts were made to locate any additional formula in the room to no avail. CPSI looked through the diaper bag in the room. CPSI located an unopened bottle of liquid Tylenol for infants and syringe that appeared to be unused. There were no other medications found in the diaper bag. [REDACTED] came in the room with a bottle of Similac Advance she had found in the refrigerator. It was the premade liquid formula in a white bottle. She reported that was the formula [REDACTED] started on Sunday morning. Detective [REDACTED] took the bottle and the formula into evidence.

CPSI did speak with [REDACTED] briefly. CPSI asked about school and field day. CPSI asked about counseling. [REDACTED] said she just started yesterday. [REDACTED] appeared clean and was dressed in clean clothes.

CPSI and Detective [REDACTED] briefly spoke with [REDACTED]. He also denied any changes in the child's behaviors. He said [REDACTED] was fed every three to four hours. He said he didn't really feed [REDACTED] or anything. [REDACTED] said he heard [REDACTED] crying early Sunday morning. He said he heard [REDACTED] out on the porch with the baby on the phone with someone. [REDACTED] said he didn't know what time he went to bed Saturday night but it was after [REDACTED] went to bed. He also denied noticing any changes in [REDACTED] behaviors throughout the week after he was discharged from the hospital.

All family members were outside on the porch. They all continued to deny any changes in [REDACTED]. They reported [REDACTED] did not spit up a lot at the house. [REDACTED] commented that [REDACTED] always burped and passed gas well.

[REDACTED] spoke with [REDACTED] on the phone and then handed the phone to CPSI. CPSI explained to [REDACTED] that she and the Detective needed to speak with her and [REDACTED] this evening or tomorrow. [REDACTED] asked why. CPSI explained that they were attempting to gather information to investigate what happened. [REDACTED] said it did not matter because her son was dead. She said there was nothing that could be done to bring him back. [REDACTED] did agree to meet with CPSI and Detective [REDACTED] at the DCS office the next day around 2:00 PM after [REDACTED] Suboxone treatment appointment at 11am.

CPSI and Detective [REDACTED] asked the family to contact them if they thought of anything else that could assist in the case.



**Tennessee Department of Children's Services  
Case Recording Summary**

Case Id: [REDACTED]  
Case Status: Close

Case Name: [REDACTED]  
Organization: [REDACTED] Region

**Case Recording Details**

Recording ID: [REDACTED] Status: Completed  
 Contact Date: 05/19/2015 Contact Method: Face To Face  
 Contact Time: 04:45 PM Contact Duration:  
 Entered By: [REDACTED] Recorded For:  
 Location: Family Home Created Date: 06/19/2015  
 Completed date: 06/19/2015 Completed By: [REDACTED]  
 Purpose(s): Permanency,Safety - Child/Community,Service Planning,Well Being  
 Contact Type(s): Collateral Contact,Other Persons Living in Home Interview/Observation,Sibling Interview/Observation  
 Contact Sub Type:

**Children Concerning**

**Participant(s)**

[REDACTED]

**Narrative Details**

Narrative Type: Original Entry Date/Time: 06/19/2015 03:36 PM Entered By: [REDACTED]

5/19/2015  
4:45 PM

Type of Contact: Initial F2F with the family

Location: Family Home; [REDACTED]

Present: Maternal Grandmother [REDACTED], Maternal Great-Grandmother [REDACTED], other household member [REDACTED] ACV's half-sibling [REDACTED]

Not Present: Mother [REDACTED] Father [REDACTED]

**Household Composition:**

[REDACTED] DOB [REDACTED] SSN [REDACTED] (mother, alleged perpetrator)  
 [REDACTED] DOB [REDACTED] (father, alleged perpetrator)  
 [REDACTED] DOB [REDACTED] SSN [REDACTED] (maternal grandmother)  
 [REDACTED] DOB [REDACTED] SSN [REDACTED] (household member)  
 [REDACTED] DOB [REDACTED] SSN [REDACTED] (maternal great-grandmother)

CPSI [REDACTED] and Detective [REDACTED] completed an unannounced visit to the family home located at [REDACTED] TN. CPSI and Detective [REDACTED] were greeted outside by the maternal grandmother and introduced themselves. Present at the time of the visit were the maternal grandmother [REDACTED] the maternal great-grandmother [REDACTED] other household member [REDACTED] and child [REDACTED]. [REDACTED] recognized CPSI from a visit to her home the week before and said hello. CPSI and Detective [REDACTED] explained the purpose of the visit to the home. CPSI and Detective [REDACTED] were informed that the parents [REDACTED] and [REDACTED] were not present at the home at that time, their exact location was unknown, and it was unknown when they would return. CPSI asked to speak with the individuals alone and in private.

CPSI and Detective [REDACTED] spoke first with the maternal grandmother [REDACTED]. She chose to



**Tennessee Department of Children's Services**  
**Case Recording Summary**

Case Id: [REDACTED]  
 Case Status: Close

Case Name: [REDACTED]  
 Organization: [REDACTED] Region

speaking outside on the front porch while the two other household members and the child remained inside the home. [REDACTED] reported she has resided in the home for approximately three years. She reported the home is made up of her, her mother [REDACTED], and family friend [REDACTED]. They rent the home from [REDACTED] and [REDACTED]. She reported the infant's parents [REDACTED] and [REDACTED] live in the home off and on. [REDACTED] said [REDACTED] was not her boyfriend. She said he was a friend that helped take care of her.

CPSI asked [REDACTED] for a timeline of events beginning the day of discharge from the birth hospital, [REDACTED] Medical Center. [REDACTED] said she did not know what they did that day. She said she remembered she cleaned the home, cleaned out the ashtrays, and did stuff around the house to prepare for the baby to arrive. She said she thought it was still light out when the baby got home that night. She said she did not notice anything different about [REDACTED] between seeing him in the hospital and seeing him at home. She talked about how [REDACTED] would try to hold his head up and would stretch like a normal baby. She reported [REDACTED] was taking Similac Gentle in the plastic bottles. She reported [REDACTED] was fed every two and a half to three hours; it was no longer than every four hours.

CPSI asked about Thursday. [REDACTED] said they got up, ate breakfast, and played with [REDACTED]. She said he liked his swing. She did not notice anything odd about his behaviors. She said [REDACTED] was burped after every 10 units of the bottle. She said there were no issues getting him to burp. She denied issues with feedings, bowel movements, or urine output. She said she thought they took [REDACTED] to a family member's home nearby to visit. She said she believed there was also a visit with the paternal grandmother [REDACTED]. She said [REDACTED] slept in his crib or bassinet Wednesday and Thursday nights. She said the bassinet was in [REDACTED] and [REDACTED] room. She said there were times she would observe [REDACTED] lying in between [REDACTED] and [REDACTED] and they were playing with him. She said they did not sleep like that. She said [REDACTED] was swaddled while lying there.

[REDACTED] said that when [REDACTED] was fed, it was like he was starving. [REDACTED] did not want to feed him too much but he just seemed hungry. [REDACTED] reported that they ran out of the Similac Gentle on Saturday night and they had to use another type. She explained it was in a white bottle. [REDACTED] reported that [REDACTED] initially breastfed [REDACTED] in the hospital but stopped when she was told that both she and [REDACTED] were Hepatitis C positive. [REDACTED] would have had to be tested again several months later. [REDACTED] reported [REDACTED] was always concerned about [REDACTED] and called everyone to make sure she was doing everything right. She said [REDACTED] really wanted a son.

[REDACTED] could not remember what the family did on Friday. [REDACTED] reported that on Saturday, [REDACTED] was seen by his doctor, Dr. [REDACTED] for his circumcision. She said she thought that was mid-morning. She said after they got back, [REDACTED] was quieter but they were told that was normal. She said he slept a lot that day but woke up to eat. She said that after the circumcision, it seemed like [REDACTED] was bleeding a lot. She said they called the doctor and were told that was normal. [REDACTED] reported she went to bed early on Saturday, around dusk or 8:30, due to a migraine. She said she did not feed [REDACTED] Saturday night. She was asked about everyone that was around [REDACTED] Saturday. [REDACTED] said it was her, her mom, [REDACTED], her brother [REDACTED], and she thought [REDACTED] son [REDACTED] was there. She said [REDACTED] is about three years old. She denied that the child was ever alone with the infant.

[REDACTED] was asked about any complications with the birth. She said the birth was quick. She said the infant was kept at the hospital longer than usual because of that. She said they were worried because [REDACTED] initially did not cry. She was asked if she could think of anything unusual about [REDACTED] behaviors, eating, etc. She denied that. She said [REDACTED] was a normal baby. She said she was told that on Sunday morning, [REDACTED] was not breathing right. She said when she woke up Sunday morning, everyone was gone. She did not see or hear [REDACTED] that morning.

CPSI asked [REDACTED] if she ever had concerns about the parents [REDACTED] and [REDACTED]. [REDACTED] said no. She said [REDACTED] had miscarriages in the past and was so happy to have a son.

CPSI and [REDACTED] discussed grief counseling. [REDACTED] reported she already receives services with [REDACTED] Mental Health in [REDACTED] and has been given resources for additional services. CPSI provided her card to [REDACTED] and encouraged [REDACTED] to contact her if she needed any additional resources or services. [REDACTED] did spend some time talking about her medical issues. She also spent time providing memories of [REDACTED]. She reported [REDACTED] friend [REDACTED] came in and stripped the room of all of [REDACTED] things. She said all of the baby items were in his room with the curtains closed. She explained that [REDACTED] and [REDACTED] room was on the right side of the home and [REDACTED] room was on the left side. She said [REDACTED] had not slept in his room.



## Tennessee Department of Children's Services

## Case Recording Summary

Case Id: [REDACTED]

Case Name: [REDACTED]

Case Status: Close

Organization: [REDACTED] Region

CPSI and Detective [REDACTED] then spoke with [REDACTED] who had come outside to check on [REDACTED]. [REDACTED] went into the home so [REDACTED] could be spoken with alone and in private. [REDACTED] provided her date of birth and social security number. [REDACTED] reported she did visit with [REDACTED] while he was at [REDACTED] Medical Center after his birth. She said she was the one that drove up to the hospital on Wednesday and drove the family home. She said [REDACTED] died on Sunday. [REDACTED] denied having any concerns about [REDACTED] after his discharge from the hospital. She denied there were any issues.

CPSI asked [REDACTED] for a timeline of events. [REDACTED] reported they got home Wednesday afternoon or evening. She said [REDACTED] ate good and burped. She said he was fine. She reported his eating, burping, bowel movements, and urine output were fine. She reported that [REDACTED] started taking formula at [REDACTED] Medical Center. She said the first formula they tried [REDACTED] did not look and so they changed it. She said it was the same brand of formula but he liked the sensitive kind better. She said they were sent home with that formula from the hospital. She said she did not believe WIC would cover the formula that [REDACTED] seemed to like more. She said [REDACTED] took all of the sensitive formula they had at the home. She said [REDACTED] was started on the other formula on Sunday morning that he was initially given. It was later discovered that when [REDACTED] began taking formula, he was given Similac Advance. They switched him to Similac Gentle. He started taking the Similac Advance again Sunday morning after they ran out of the gentle type.

[REDACTED] could not think of anything out of the ordinary that took place last week. She initially could not remember what they did on Friday. She said on Saturday, [REDACTED] was circumcised. She said [REDACTED] wanted to do it the biblical way. She said Dr. [REDACTED] completed the circumcision. She said [REDACTED] was fine on Saturday. She said Dr. [REDACTED] played with him and so did Dr. [REDACTED] daughter. She thought the daughter was 15 or 16. [REDACTED] said after that, they went to see a friend, [REDACTED]. They wanted [REDACTED] to see his great-grandfather but he was sick so they could not. She said they sat outside with the friend for twenty or thirty minutes, left, and came back home. She said she thought it was around noon when they got back home. She said [REDACTED] was fine. CPSI asked [REDACTED] about how often [REDACTED] was fed. [REDACTED] said it was about every three hours. She reported [REDACTED] was eating well. She said [REDACTED] always acted hungry. She said [REDACTED] was worried she was going to feed [REDACTED] too much. She said [REDACTED] was worried on Saturday about [REDACTED] circumcision bleeding.

[REDACTED] reported that on Sunday morning she was asleep. She said [REDACTED] brought [REDACTED] to her and said something was wrong. [REDACTED] said she told [REDACTED] to call Dr. [REDACTED]. [REDACTED] said [REDACTED] appeared white and was cold. She explained she put a cap on [REDACTED] head, put a blanket around him, and held him to her body to keep him warm. She said they had Dr. [REDACTED] on the phone and she heard the sound [REDACTED] was making. She said [REDACTED] was in the kitchen walking around when that was happening. [REDACTED] was asked about the noise. [REDACTED] said it was like [REDACTED] was straining to have a bowel movement but was having a hard time breathing. She said it was so strange. [REDACTED] said she thought [REDACTED] had ate about an hour before she was woken up. She said she did not know. She said she thought it was dark when [REDACTED] woke her up. [REDACTED] was asked about how [REDACTED] was fed. She said he was never laid flat to eat. She said he was held up with his head elevated. [REDACTED] said the only thing she could think of that changed with [REDACTED] was his formula on Sunday morning. She said she was not sure where the formula was now. She said she thought someone bagged up the formula and took it to get tested.

[REDACTED] was asked again about [REDACTED] behaviors. She denied any concerns. [REDACTED] was asked about [REDACTED] and [REDACTED]. [REDACTED] denied any concerns. She said she was so proud of [REDACTED]. She said she had been worried about [REDACTED] for a while in the past, but she was doing so much better. [REDACTED] said that after they left the hospital Sunday, [REDACTED] laid down in the back and [REDACTED] laid the front passenger seat back. They held each other. She said [REDACTED] was working a lot. When he got home, he would spend time with [REDACTED]. He said they would just lay there and stare into each other's eyes.

[REDACTED] was asked to name everyone that saw [REDACTED] on Saturday. She said [REDACTED] was around her, [REDACTED] Dr. [REDACTED] her daughter, [REDACTED], [REDACTED] her son, [REDACTED] his wife [REDACTED] and their child [REDACTED]. [REDACTED] had come outside while [REDACTED] was providing the names of everyone that saw [REDACTED] on Saturday. She added that family friend [REDACTED] had come over that day. She said [REDACTED] did not hold or touch [REDACTED]. [REDACTED] reported she went to bed around 12:30 or 12:45 am that night.

CPSI asked [REDACTED] again if she could think of anything that had changed about [REDACTED]. [REDACTED] spoke up and said [REDACTED] had some diarrhea at the hospital when his formula was changed. It was reported that [REDACTED] was worried about [REDACTED] sleeping so much on Saturday. [REDACTED] said [REDACTED] told her she woke up a little after 2am, fed [REDACTED]



## Tennessee Department of Children's Services

### Case Recording Summary

Case Id: [REDACTED]

Case Name: [REDACTED]

Case Status: Close

Organization: [REDACTED] Region

put him to bed, and then woke up again about 4:15 or 4:25am. [REDACTED] was fed, went back to sleep, and then woke up around 5:30am. She said [REDACTED] said [REDACTED] was cold and white so they called the doctor.

[REDACTED] and [REDACTED] were not able to say if [REDACTED] slept in his swing or bassinet in the room with [REDACTED] and [REDACTED] on Saturday night. Both denied having any concerns or seeing any issues with [REDACTED] on Saturday night.

[REDACTED] when on to talk about her religious beliefs, how she had encouraged [REDACTED] and [REDACTED] on Sunday, and a song she has been listening to, to help her cope.

CPSI was given permission to enter the home. [REDACTED] and [REDACTED] walked CPSI through the home. CPSI took pictures of the home. The front door leads to the living room. Immediately to the left is [REDACTED] room. [REDACTED] identified the corner of the living room where [REDACTED] swing was kept. After walking straight from the door and through the living room, you enter the kitchen. Immediately to the right is [REDACTED] and [REDACTED] room. The door was closed to the room. CPSI was allowed to enter the room to take pictures. There is a bed to the left of the door. [REDACTED] identified where [REDACTED] bassinet was placed in the room. It was in the middle of the room between the bed and a table. Prescription medication bottles were observed on a table in the room. [REDACTED] was prescribed Ibuprofen 800mg, fluoxetine, and nipple cream from [REDACTED] Medical Center. Across the hall and to the left of the kitchen was a room identified as [REDACTED] room. There were two cradles described as bassinets, a cradle swing, and a bouncy seat. The family had moved all of the infant's belongings into the room and out of the other rooms of the house. The family had clothing, diapers, wipes, and other necessities for the infant. [REDACTED] reported that [REDACTED] either slept in one of the cradles or the cradle swing. At the back of the home past the kitchen, [REDACTED] sleeps in back hallway area. It was reported [REDACTED] was only residing in the home until her home could be repaired. [REDACTED] reportedly sleeps in the living room.

After Detective [REDACTED] was given consent to search the home, he entered to take pictures. CPSI completed another walkthrough with Detective [REDACTED] and the family. While in [REDACTED] room, a bottle with formula in it was found [REDACTED] said she was not aware of when that bottle was made. Attempts were made to locate any additional formula in the room to no avail. CPSI looked through the diaper bag in the room. CPSI located an unopened bottle of liquid Tylenol for infants and syringe that appeared to be unused. There were no other medications found in the diaper bag. [REDACTED] came in the room with a bottle of Similac Advance she had found in the refrigerator. It was the premade liquid formula in a white bottle. She reported that was the formula [REDACTED] started on Sunday morning. Detective [REDACTED] took the bottle and the formula into evidence.

CPSI did speak with [REDACTED] briefly. CPSI asked about school and field day. CPSI asked about counseling. [REDACTED] said she just started yesterday. [REDACTED] appeared clean and was dressed in clean clothes.

CPSI and Detective [REDACTED] briefly spoke with [REDACTED]. He also denied any changes in the child's behaviors. He said [REDACTED] was fed every three to four hours. He said he didn't really feed [REDACTED] or anything. [REDACTED] said he heard [REDACTED] crying early Sunday morning. He said he heard [REDACTED] out on the porch with the baby on the phone with someone. [REDACTED] said he didn't know what time he went to bed Saturday night but it was after [REDACTED] went to bed. He also denied noticing any changes in [REDACTED] behaviors throughout the week after he was discharged from the hospital.

All family members were outside on the porch. They all continued to deny any changes in [REDACTED]. They reported [REDACTED] did not spit up a lot at the house. [REDACTED] commented that [REDACTED] always burped and passed gas well.

[REDACTED] spoke with [REDACTED] on the phone and then handed the phone to CPSI. CPSI explained to [REDACTED] that she and the Detective needed to speak with her and [REDACTED] this evening or tomorrow. [REDACTED] asked why. CPSI explained that they were attempting to gather information to investigate what happened. [REDACTED] said it did not matter because her son was dead. She said there was nothing that could be done to bring him back. [REDACTED] did agree to meet with CPSI and Detective [REDACTED] at the DCS office the next day around 2:00 PM after [REDACTED] Suboxone treatment appointment at 11am.

CPSI and Detective [REDACTED] asked the family to contact them if they thought of anything else that could assist in the case.



**Tennessee Department of Children's Services**  
**Case Recording Summary**

Case Id: [REDACTED]	Case Name: [REDACTED]
Case Status: Close	Organization: [REDACTED] Region

**Case Recording Details**

Recording ID: [REDACTED]	Status: System Completed
Contact Date: 05/19/2015	Contact Method: Correspondence
Contact Time: 03:33 PM	Contact Duration: Less than 05
Entered By: [REDACTED]	Recorded For:
Location:	Created Date: 05/22/2015
Completed date: 06/19/2015	Completed By: System Completed
Purpose(s): Permanency,Safety - Child/Community,Service Planning,Well Being	
Contact Type(s): Collateral Contact	
Contact Sub Type:	

**Children Concerning****Participant(s)****Narrative Details**

Narrative Type: Original      Entry Date/Time: 05/22/2015 12:38 PM      Entered By: [REDACTED]

5/19/2015

CPSI requested [REDACTED] medical records from [REDACTED] Family Practice, [REDACTED] Hospital Association, and [REDACTED] Medical Center. CPSI requested [REDACTED]'s medical records from [REDACTED] Hospital Association, [REDACTED] and [REDACTED] Medical Center.

05/19/2015

While meeting with Detective [REDACTED] about this case, he contacted the office of the Regional Forensic Center regarding the reported autopsy of the child. It was confirmed that the autopsy had been completed but the provisional report was not yet complete. Detective [REDACTED] was given the following information about what led the child to be taken to the emergency room: The child was reportedly "not eating right" that night. They woke up about 4am. The child's heart rate was 135. The child had last eaten one to two ounces of Similac formula. The infant was making weird noises and was taken to the emergency room.

05/19/2015

CPSI received [REDACTED] medical records from [REDACTED] Medicine on this date at 3:33 PM. [REDACTED] was seen by Dr. [REDACTED] at [REDACTED] Medicine on 05/15/2015 and 05/16/2015.

[REDACTED] appointment on 05/15/2015 was for a new well child visit. [REDACTED] birth weight was listed as 7lbs 6oz. His weight on the date of the appointment was 7lbs 2.5oz. It was noted that [REDACTED] hepatitis C antibody was positive. He was born by normal vaginal delivery. There was Suboxone exposure. It was noted that DCS is following the care of the child at home due to NAS risk. Newborn metabolic screening was done at birth and results are pending. It was noted that he was not breastfed, there were no feeding problems reported, the mother brought a paper log of feedings, and he is getting 45-58 ml per feeding of similac sensitive. [REDACTED] stool was reported to be normal consistency. He was voiding urine well. He smiles responsively, as adaptive equal movements of all extremities, and follows to midline. He responds to sound. His breathing pattern was normal, no apnea, cough denied. He responds to talking to him and lifts head. There were no concerns of abuse or neglect. He appeared alert and well nourished. It was noted that the mother wanted to bring the baby in the next day for circumcision. It was noted that the doctor mentioned they wanted [REDACTED] to be back to his birth weight by two weeks of life.



**Tennessee Department of Children's Services**  
**Case Recording Summary**

Case Id: [REDACTED]

Case Name: [REDACTED]

Case Status: Close

Organization: [REDACTED] Region

[REDACTED] was seen on 05/16/2015 for his circumcision. There were no concerns noted. He was to follow up in one week for a weight check and to check the circumcision. He tolerated the procedure well.

The medical records received contained a "progress note" from [REDACTED] Hospital Association dated 05/17/2015. The note was by Dr. [REDACTED].

"I was called at 06:14 a.m. this morning by the mother of the baby [REDACTED] who is a 9-day-old infant who I had seen initially in the office on Friday and then again Saturday which was yesterday when I did a circumcision on him. She states that she had been getting him up about every 2 hours to eat during the night and he had had a little bit of oozing from the end of his penis from the circumcision so she had been reapplying a dressing. However, when she called me at 06:14 she said he was "breathing funny" and was waxy and white. Then she said she had been changing his dressings from the circ we did at the office at 10 o'clock earlier in the day and it was still oozing a bit. I directed her to the closest emergency room so she showed up at [REDACTED] Hospital within 15-20 minutes. I drove into the hospital and was here by 7 a.m. I observed a baby that was very pale with supportive breathing and aging in progress. I arrived at the hospital staying by his bedside since that time until we coded him, other than when I left the bedside to go to the nursing station to talk to the emergency room physician from Children's Hospital who had called in and the emergency room crew from Children's who were en route. I assisted with head positioning and bagging. Hemoglobin on heel stick was 9. Nurses had attempted IV access without success. Anesthesia was brought in. They intubated him numerous times. It was very difficult to intubate both by anesthesia and by myself. I did attempt oral intubation twice. I saw vocal cords on the second attempt but did not have any respiratory sounds so we removed the tube. They finally brought in a GlideScope which helped visualize his vocal cords and gave us a successful intubation. The infant would grimace, "blink eyes", have abdominal retractions with breathing. It was very difficult to obtain on the monitor a heart rate but on auscultation we heard an irregular "funny" heart rate per nursing and I listened and noted it to be between 70-100 and decreasing. It was difficult to maintain an intubation and respiratory access. The baby continued to deteriorate. A right tibial interosseous was placed per nursing and normal saline and IV bolus of 6 cc and then I talked to the Children's Emergency Room physician who recommended a 60 cc IV bolus push. We were able to get 27.5 roughly cc in him before that interosseous blew. We attempted an left interosseous per nursing with no success. A blood sugar was drawn and it was 186. I talked numerous times to Children's Emergency Room and they and we felt the infant was too unstable to be transported in our adult ambulance and they were already en route as fast as they could. They recommended to continue the bag and support his respiratory status. We did visualize the vocal cords with the GlideScope and verified placement of the ET tube. He did extubate twice but we were able to then get it back in. Anesthesia felt and we all felt that there was some foreign body appearing or foreign tube that appeared in the back of the posterior pharynx competing the attempts at intubation that we could see on the GlideScope that was also radiopaque on x-ray. We were not able to pull it out or to figure out what it was exactly that this object was. The infant developed agonal then no respirations and a very poor heart rate and terminal bradycardia. We continued to run a code on him until epinephrine was given x 2 Subcu and x 2 down the ET tube at a 1 and 10,000 dose and without success and one dose of 1 and 1,000 was offered through the ET tube Children's Hospital Support Group. After coding him for 2 ¼ hours without any success and I noted the baby to have no corneal reflexes, no heartbeat, no breathing spontaneously, no response to painful stimulus, he was pronounced at 09:15 a.m. I talked to the family at length multiple times and explained exactly what we were able to do. They had a lot of questions about how this happened which I cannot answer at this time. The baby will be sent for autopsy to try to ascertain exactly what happened in this particular case."



**Tennessee Department of Children's Services**  
**Case Recording Summary**

Case Id: [REDACTED]	Case Name: [REDACTED]
Case Status: Close	Organization: [REDACTED] Region

**Case Recording Details**

Recording ID: [REDACTED]	Status: Completed
Contact Date: 05/19/2015	Contact Method: Correspondence
Contact Time: 03:33 PM	Contact Duration:
Entered By: [REDACTED]	Recorded For:
Location:	Created Date: 06/19/2015
Completed date: 06/19/2015	Completed By: [REDACTED]
Purpose(s): Permanency,Safety - Child/Community,Service Planning,Well Being	
Contact Type(s): Collateral Contact	
Contact Sub Type:	

**Children Concerning****Participant(s)****Narrative Details**

Narrative Type: Original      Entry Date/Time: 06/19/2015 03:34 PM      Entered By: [REDACTED]

5/19/2015

CPSI requested [REDACTED] medical records from [REDACTED] Family Practice, [REDACTED] Hospital Association, and [REDACTED] Medical Center. CPSI requested [REDACTED] medical records from [REDACTED] Hospital Association, [REDACTED] and [REDACTED] Medical Center.

05/19/2015

While meeting with Detective [REDACTED] about this case, he contacted the office of the [REDACTED] Forensic Center regarding the reported autopsy of the child. It was confirmed that the autopsy had been completed but the provisional report was not yet complete. Detective [REDACTED] was given the following information about what led the child to be taken to the emergency room: The child was reportedly "not eating right" that night. They woke up about 4am. The child's heart rate was 135. The child had last eaten one to two ounces of Similac formula. The infant was making weird noises and was taken to the emergency room.

05/19/2015

CPSI received [REDACTED] medical records from [REDACTED] Family Medicine on this date at 3:33 PM. [REDACTED] was seen by Dr. [REDACTED] at [REDACTED] Family Medicine on 05/15/2015 and 05/16/2015.

[REDACTED] appointment on 05/15/2015 was for a new well child visit. [REDACTED] birth weight was listed as 7lbs 6oz. His weight on the date of the appointment was 7lbs 2.5oz. It was noted that [REDACTED] hepatitis C antibody was positive. He was born by normal vaginal delivery. There was Suboxone exposure. It was noted that DCS is following the care of the child at home due to NAS risk. Newborn metabolic screening was done at birth and results are pending. It was noted that he was not breastfed, there were no feeding problems reported, the mother brought a paper log of feedings, and he is getting 45-58 ml per feeding of similac sensitive. [REDACTED] stool was reported to be normal consistency. He was voiding urine well. He smiles responsively, as adaptive equal movements of all extremities, and follows to midline. He responds to sound. His breathing pattern was normal, no apnea, cough denied. He responds to talking to him and lifts head. There were no concerns of abuse or neglect. He appeared alert and well nourished. It was noted that the mother wanted to bring the baby in the next day for circumcision. It was noted that the doctor mentioned they wanted [REDACTED] to be back to his birth weight by two weeks of life.



**Tennessee Department of Children's Services**  
**Case Recording Summary**

Case Id: [REDACTED]

Case Name: [REDACTED]

Case Status: Close

Organization: [REDACTED] Region

[REDACTED] was seen on 05/16/2015 for his circumcision. There were no concerns noted. He was to follow up in one week for a weight check and to check the circumcision. He tolerated the procedure well.

The medical records received contained a "progress note" from [REDACTED] Hospital Association dated 05/17/2015. The note was by Dr [REDACTED].

"I was called at 06:14 a.m. this morning by the mother of the baby [REDACTED] who is a 9-day-old infant who I had seen initially in the office on Friday and then again Saturday which was yesterday when I did a circumcision on him. She states that she had been getting him up about every 2 hours to eat during the night and he had had a little bit of oozing from the end of his penis from the circumcision so she had been reapplying a dressing. However, when she called me at 06:14 she said he was "breathing funny" and was waxy and white. Then she said she had been changing his dressings from the circ we did at the office at 10 o'clock earlier in the day and it was still oozing a bit. I directed her to the closest emergency room so she showed up at [REDACTED] Hospital within 15-20 minutes. I drove into the hospital and was here by 7 a.m. I observed a baby that was very pale with supportive breathing and aging in progress. I arrived at the hospital staying by his bedside since that time until we coded him, other than when I left the bedside to go to the nursing station to talk to the emergency room physician from Children's Hospital who had called in and the emergency room crew from Children's who were en route. I assisted with head positioning and bagging. Hemoglobin on heel stick was 9. Nurses had attempted IV access without success. Anesthesia was brought in. They intubated him numerous times. It was very difficult to intubate both by anesthesia and by myself. I did attempt oral intubation twice. I saw vocal cords on the second attempt but did not have any respiratory sounds so we removed the tube. They finally brought in a GlideScope which helped visualize his vocal cords and gave us a successful intubation. The infant would grimace, "blink eyes", have abdominal retractions with breathing. It was very difficult to obtain on the monitor a heart rate but on auscultation we heard an irregular "funny" heart rate per nursing and I listened and noted it to be between 70-100 and decreasing. It was difficult to maintain an intubation and respiratory access. The baby continued to deteriorate. A right tibial interosseous was placed per nursing and normal saline and IV bolus of 6 cc and then I talked to the Children's Emergency Room physician who recommended a 60 cc IV bolus push. We were able to get 27.5 roughly cc in him before that interosseous blew. We attempted an left interosseous per nursing with no success. A blood sugar was drawn and it was 186. I talked numerous times to Children's Emergency Room and they and we felt the infant was too unstable to be transported in our adult ambulance and they were already en route as fast as they could. They recommended to continue the bag and support his respiratory status. We did visualize the vocal cords with the GlideScope and verified placement of the ET tube. He did extubate twice but we were able to then get it back in. Anesthesia felt and we all felt that there was some foreign body appearing or foreign tube that appeared in the back of the posterior pharynx competing the attempts at intubation that we could see on the GlideScope that was also radiopaque on x-ray. We were not able to pull it out or to figure out what it was exactly that this object was. The infant developed agonal then no respirations and a very poor heart rate and terminal bradycardia. We continued to run a code on him until epinephrine was given x 2 Subcu and x 2 down the ET tube at a 1 and 10,000 dose and without success and one dose of 1 and 1,000 was offered through the ET tube Children's Hospital Support Group. After coding him for 2 ¼ hours without any success and I noted the baby to have no corneal reflexes, no heartbeat, no breathing spontaneously, no response to painful stimulus, he was pronounced at 09:15 a.m. I talked to the family at length multiple times and explained exactly what we were able to do. They had a lot of questions about how this happened which I cannot answer at this time. The baby will be sent for autopsy to try to ascertain exactly what happened in this particular case."



**Tennessee Department of Children's Services**  
**Case Recording Summary**

Case Id: [REDACTED]  
 Case Status: Close

Case Name: [REDACTED]  
 Organization: [REDACTED] Region

**Case Recording Details**

Recording ID: [REDACTED] Status: Completed  
 Contact Date: 05/19/2015 Contact Method: Correspondence  
 Contact Time: 03:11 PM Contact Duration: Less than 05  
 Entered By: [REDACTED] Recorded For:  
 Location: Created Date: 05/22/2015  
 Completed date: 05/22/2015 Completed By: [REDACTED]  
 Purpose(s): Permanency,Safety - Child/Community,Service Planning,Well Being  
 Contact Type(s): Referent Interview  
 Contact Sub Type:

**Children Concerning**

**Participant(s)**

**Narrative Details**

Narrative Type: Original Entry Date/Time: 05/22/2015 10:45 AM Entered By: [REDACTED]  
 05/19/2015  
 Referent notified of case assignment.



**Tennessee Department of Children's Services**  
**Case Recording Summary**

Case Id: [REDACTED]  
 Case Status: Close

Case Name: [REDACTED]  
 Organization: [REDACTED] Region

**Case Recording Details**

Recording ID:	[REDACTED]	Status:	Completed
Contact Date:	05/19/2015	Contact Method:	Face To Face
Contact Time:	01:00 PM	Contact Duration:	Less than 05
Entered By:	[REDACTED]	Recorded For:	
Location:	DCS Office	Created Date:	05/22/2015
Completed date:	05/22/2015	Completed By:	[REDACTED]
Purpose(s):	Service Planning		
Contact Type(s):	Initial ACV Face To Face,Notation		
Contact Sub Type:			

**Children Concerning**

[REDACTED]

**Participant(s)**

[REDACTED]

**Narrative Details**

Narrative Type: Original      Entry Date/Time: 05/22/2015 08:21 AM      Entered By: [REDACTED]

5/19/2015

The child died on 05/17/2015. The child was transferred for autopsy on 05/17/2015. The Department was not notified of the child's death until 05/19/2015. Response was met by convening the Child Protective Investigative Team and beginning the investigation.



**Tennessee Department of Children's Services**  
**Case Recording Summary**

Case Id: [REDACTED]	Case Name: [REDACTED]
Case Status: Close	Organization: [REDACTED] Region

**Case Recording Details**

Recording ID: [REDACTED]	Status: Completed
Contact Date: 05/19/2015	Contact Method: Face To Face
Contact Time: 01:00 PM	Contact Duration: Less than 05
Entered By: [REDACTED]	Recorded For:
Location: DCS Office	Created Date: 05/22/2015
Completed date: 05/22/2015	Completed By: [REDACTED]
Purpose(s): Permanency,Safety - Child/Community,Service Planning,Well Being	
Contact Type(s): CPIT (Child Protective Investigative Team)	
Contact Sub Type:	

**Children Concerning****Participant(s)****Narrative Details**

Narrative Type: Original      Entry Date/Time: 05/22/2015 08:37 AM      Entered By: [REDACTED]

The [REDACTED] County Child Protective Investigative Team (CPIT) was convened on 05/19/2015 with Detective [REDACTED] with [REDACTED] County Sheriff's Office [REDACTED] with the [REDACTED] Judicial District Attorney's Office was notified by Detective [REDACTED]

**Next steps identified:**

CPSI will request all medical records. Detective [REDACTED] notified the appropriate professionals to begin the process to obtain subpoenas for medical records. Detective [REDACTED] will follow up with the Forensic Center in [REDACTED] County and the medical examiner's office regarding the child's autopsy. CPSI and Detective [REDACTED] will complete a visit to the home to complete interviews, gather information, and take pictures of the home.



**Tennessee Department of Children's Services**  
**Case Recording Summary**

Case Id: [REDACTED]	Case Name: [REDACTED]
Case Status: Close	Organization: [REDACTED] Region

**Case Recording Details**

Recording ID: [REDACTED]	Status: Completed
Contact Date: 05/19/2015	Contact Method:
Contact Time: 11:45 AM	Contact Duration: Less than 05
Entered By: [REDACTED]	Recorded For:
Location:	Created Date: 05/21/2015
Completed date: 05/22/2015	Completed By: [REDACTED]
Purpose(s): Permanency,Safety - Child/Community,Service Planning,Well Being	
Contact Type(s): Case Summary	
Contact Sub Type:	

**Children Concerning****Participant(s)****Narrative Details**

Narrative Type: Original      Entry Date/Time: 05/21/2015 12:46 PM      Entered By: [REDACTED]

This case was assigned to CPSI [REDACTED] on 05/19/2015. The District Attorney's office is notified of all severe abuse cases per local protocol. Upon classification the District Attorney is notified at the Child Protective Investigative Team (CPIT) monthly meeting. Juvenile Court judges are notified of all referrals per local protocol. Notice of classification is submitted to the Juvenile Court Judge per local protocol via the 740. The allegations reported are: and neglect death with alleged child victim (ACV) [REDACTED] and alleged perpetrators mother [REDACTED] and [REDACTED]

The referral states the following:

[REDACTED] (11 days) was in the care of his parents, [REDACTED] and [REDACTED]. [REDACTED] is currently deceased. [REDACTED] passed Sunday, May 17, 2015. [REDACTED] states that [REDACTED] passed away at [REDACTED] Hospital Association in [REDACTED] Tennessee. [REDACTED] states that [REDACTED] was taken to the hospital due to concerns of him breathing abnormally. [REDACTED] states that this was around 4:00 a.m. Referent believes that [REDACTED] and [REDACTED] transported [REDACTED] to the hospital. [REDACTED] states that they took him to the hospital. [REDACTED] indicated that [REDACTED] was still breathing while en route to the hospital. [REDACTED] states that medical personnel worked on [REDACTED] for two hours, but that they were "unable to fix it." [REDACTED] states that a tube was placed inside of [REDACTED] to help him breathe, and that formula came out. It is unclear if formula came out of the tube or out of [REDACTED] mouth. [REDACTED] states that Medical Personnel made statements indicating that something could have been wrong with [REDACTED] throat, and it may not have developed properly. [REDACTED] states that the hospital is conducting an autopsy. The county Detective [REDACTED] has been contacted, and he indicated that he was not made aware of the incident. Mr [REDACTED] was contacted today. This is possibly due to [REDACTED] passing away at the hospital.

[REDACTED] (Maternal Grandmother) and [REDACTED] (Paramour) reside in the home; however, the only adult in the home that has been contacted at this time is [REDACTED]. Referent states that [REDACTED] was contacted by the current CPS Investigator [REDACTED] Ms. [REDACTED] is currently involved with the family due to allegations of Drug Exposed Infant and Drug Exposed Child involving [REDACTED] and [REDACTED]. [REDACTED] is [REDACTED] other child. [REDACTED] is currently in the care of Paternal Grandmother, [REDACTED] since 2013. [REDACTED] does have another grandchild, [REDACTED] (4) that lives in the home. [REDACTED] is not [REDACTED] child and [REDACTED] Father is [REDACTED]. [REDACTED] has supervised visits with [REDACTED] and [REDACTED] on the weekends. [REDACTED] has unsupervised with [REDACTED] every other weekend. It is unknown where [REDACTED] and [REDACTED] are at this time. There are no other concerns of abuse at this time. [REDACTED] has a history of incarceration to drugs in the past (2013). [REDACTED]



**Tennessee Department of Children's Services**  
**Case Recording Summary**

Case Id: [REDACTED]

Case Name: [REDACTED]

Case Status: Close

Organization: [REDACTED] Region

and [REDACTED] have a history of using drugs. [REDACTED] and [REDACTED] are currently using non-prescribed Suboxone. There was a meconium test completed when [REDACTED] was born. Those results are still pending.

The current Case ID: [REDACTED]

**DCS History:**

At the time of the child's death and the referral, there was an open investigation, ID # [REDACTED]. The allegations were drug exposed infant with [REDACTED] listed as the alleged child victim (ACV) and drug exposed child with another child listed as ACV. The alleged perpetrator was the mother [REDACTED]. It was reported that the mother had used non-prescribed Suboxone throughout her pregnancy.

There were no other previous or open investigations regarding this ACV.

History on the other child involved in the open case can be found in investigation [REDACTED]

The mother [REDACTED] has history with the Department as an alleged perpetrator. A case was opened in October 2011 (investigation [REDACTED]). She was substantiated as a perpetrator of drug exposed child with her only other child listed as the ACV. The child was removed from her care and custody.

The father [REDACTED] was listed as an alleged perpetrator in a referral made in March 2013 (investigation [REDACTED]). He was substantiated as a perpetrator of drug exposed child and lack of supervision. He has other children that are not in his care and custody that have been involved with the Department.



**Tennessee Department of Children's Services**  
**SDM™ Safety Assessment**

**Assessment**

Family Name: [REDACTED]

TN DCS Intake ID #: [REDACTED]

County: [REDACTED]

Worker:

Date of Referral: 4/17/15 3:29 PM

Date of Assessment: 4/24/15 12:00 AM

Assessment Type: Initial

Number of Children in the Household: 2

**Section 1: Immediate Harm Factors**

Directions: The following factors are behaviors or conditions that may be associated with a child being in immediate danger of serious harm. Identify the presence of absence of each factor by making either "yes" or "no". Note: The vulnerability of each child needs to be considered throughout the assessment. Children ages zero through six cannot protect themselves. For older children, inability to protect themselves could result from diminished mental or physical capacity or repeated victimization.

Yes No

1. Caretaker caused serious physical harm to the child, or made a plausible threat to cause serious physical harm in the current investigation indicated by (check all that apply):
- Serious injury or abuse to child other than accidental.
  - Death of a child due to abuse or neglect.
  - Care taker fears that s/he will maltreat the child.
  - Threat to cause harm or retaliate against the child.
  - Excessive discipline or physical force.
  - Drug-affected infant/child.
  - Methamphetamine lab exposure.
2. Child sexual abuse is suspected, and circumstances suggest that the child's safety may be of immediate concern.
3. Caretaker fails to protect the child from serious harm or threatened harm by others. This may include physical abuse, sexual abuse, or neglect.
4. Caretaker's explanation for the injury to the child is questionable or inconsistent with the type of injury, and the nature of the injury suggests that the child's safety may be of immediate concern.
5. The family refuses access to the child, or there is reason to believe that the family is about to flee.
6. Caretaker does not meet the child's immediate needs for supervision, food, clothing, and/or medical or mental health care.
7. The physical living conditions are hazardous and immediately threatening to the health and/or safety of the child.
8. Caretaker's current substance abuse seriously impairs his/her ability to supervise, protect, or care for the child.
9. Domestic violence exists in the home and poses a risk of serious physical and/or emotional harm to the child.



## Tennessee Department of Children's Services

### SDM™ Safety Assessment

10. Caretaker describes the child in predominantly negative terms or acts toward the child in negative ways that result in the child being a danger to self or others, acting out aggressively, or being severely withdrawn and/or suicidal.
11. Caretaker's emotional stability, developmental status, or cognitive deficiency seriously impairs his/her current ability to supervise, protect, or care for the child.
12. There is a pattern of prior investigations and/or behavior that suggests an escalating threat to child safety.
13. Other (specify)

**If no immediate harm factors are observed, proceed to Section 3**

#### Section 2: Safety Interventions

If no immediate harm factors are present, go to Section 3. If one or more immediate harm factors are present, consider whether safety interventions one through eight will allow the child to remain in the home for the present time. Check the item number for all safety interventions that will be implemented. If there are no available safety interventions that would allow the child to remain in the home, indicate by checking item nine or ten, and follow procedures for initiating a voluntary agreement or taking the child into protective custody. Mark all that apply:

#### Non-Protective Custody Interventions:

1. Intervention or direct services by worker as part of a safety plan.
2. Use of family, neighbors, or other individuals in the community as safety resources.
3. Use of community agencies or services as immediate safety resources.
4. Have caretaker appropriately protect the victim from the alleged perpetrator.
5. Have the alleged perpetrator leave the home, either voluntarily or in response to legal action.
6. Have the non-offending caretaker move to a safe environment with the child.
7. Legal action planned or initiated - child remains in the home.
8. Other (Specify): \_\_\_\_\_

#### Protective Custody Interventions:

9. Caretaker signs a voluntary placement agreement that places the child in Department of Children Services (DCS) custody.
10. Child placed in protective custody pursuant to 37-1-113 and 37-1-117 because no interventions are available to adequately ensure the child's safety.



**Tennessee Department of Children's Services**  
**SDM™ Safety Assessment**

**Section 3: Safety Decision**

Identify the safety decision. This decision should be based on the assessment of all immediate harm factors, safety interventions, and any other information known about the family. Mark only one.

- 1. **Safe.** No immediate harm factors were identified at this time. Based on currently available information, there are no children likely to be in immediate danger of serious harm.
- 2. **Conditionally Safe.** One or more immediate harm factors are present, and one or more protecting interventions #1-8 have been planned or taken. Based on protecting interventions, no protective custody action is necessary at this time.
- 3. **Unsafe.** One or more immediate harm factors are present, and placement is the only protecting intervention (#9 or #10) possible for one or more children. Without placement, one or more children will likely be in danger of immediate or serious harm.
  - All children placed.
  - One or more children being placed in protective custody, but others remain in the home. Complete the status of each child below only when one or more children are being removed, but others remain in the home:

**Children Removed**

**Children Not Removed**

**Case Manager:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Team Leader:** \_\_\_\_\_

**Date:** \_\_\_\_\_



**Tennessee Department of Children's Services**  
**SDM™ Safety Assessment**

**Assessment**

Family Name: [REDACTED]  
 County: [REDACTED]  
 Date of Referral: 5/11/15 11:27 AM  
 Assessment Type: Initial

TN DCS Intake ID #: [REDACTED]  
 Worker:  
 Date of Assessment: 5/12/15 12:00 AM  
 Number of Children in the Household: 1

**Section 1: Immediate Harm Factors**

Directions: The following factors are behaviors or conditions that may be associated with a child being in immediate danger of serious harm. Identify the presence or absence of each factor by making either "yes" or "no". Note: The vulnerability of each child needs to be considered throughout the assessment. Children ages zero through six cannot protect themselves. For older children, inability to protect themselves could result from diminished mental or physical capacity or repeated victimization.

Yes No

- |                          |                                     |  |
|--------------------------|-------------------------------------|--|
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 1. Caretaker caused serious physical harm to the child, or made a plausible threat to cause serious physical harm in the current investigation indicated by (check all that apply):                        |
|                          | <input type="checkbox"/>            | Serious injury or abuse to child other than accidental.  |
|                          | <input type="checkbox"/>            | Death of a child due to abuse or neglect.  |
|                          | <input type="checkbox"/>            | Care taker fears that s/he will maltreat the child.  |
|                          | <input type="checkbox"/>            | Threat to cause harm or retaliate against the child.   |
|                          | <input type="checkbox"/>            | Excessive discipline or physical force.  |
|                          | <input type="checkbox"/>            | Drug-affected infant/child.  |
|                          | <input type="checkbox"/>            | Methamphetamine lab exposure.  |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 2. Child sexual abuse is suspected, and circumstances suggest that the child's safety may be of immediate concern.   |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 3. Caretaker fails to protect the child from serious harm or threatened harm by others. This may include physical abuse, sexual abuse, or neglect.   |
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| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 5. The family refuses access to the child, or there is reason to believe that the family is about to flee.   |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 6. Caretaker does not meet the child's immediate needs for supervision, food, clothing, and/or medical or mental health care.  |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 7. The physical living conditions are hazardous and immediately threatening to the health and/or safety of the child.  |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 8. Caretaker's current substance abuse seriously impairs his/her ability to supervise, protect, or care for the child.   |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 9. Domestic violence exists in the home and poses a risk of serious physical and/or emotional harm to the child.   |



## Tennessee Department of Children's Services

### SDM™ Safety Assessment

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12. There is a pattern of prior investigations and/or behavior that suggests an escalating threat to child safety.
13. Other (specify)

**If no immediate harm factors are observed, proceed to Section 3**

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Tennessee Department of Children's Services  
SDM™ Safety Assessment

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