County	Name	Date of Death	Age	Cause of Death	Case Notes
Alexander	Isaiah Raygan Wallace	10/30/10	4 months	SIDS; chronic lung disease of prematurity; Rhinovirus; URI	Isaiah's oldest sibling died 4 years prior to Isaiah's death. Critical information possessed by some community service providers regarding risk to Isaiah was not communicated to the Alexander County Department of Social Services to assure a thorough child protective services investigative assessment. A Child and Family Team Meeting was conducted prior to the first twin being discharged from the hospital leading to the child welfare staff recommendation to assume custody of the infants. They were instructed not to file following legal consultation. A second Child and Family Team Meeting was not held prior to the discharge of Isaiah from the hospital to fully evaluate the care Isaiah's brother was receiving after release from the hospital and reassess the safety risks and plans.
Alleghany	Brandon Lee Perry	11/23/09	11 yrs	Multiple Blunt Force Trauma - Auto Accident	Father had history of domestic abuse but was not required to complete abuser treatment; County was unaware of numerous contacts made by parents seeking prescription drugs; mother tested positive for marijuana six days prior to trial placement of juvenile
Cabarrus	Marcus Benjamin	08/30/08	5 months	Head Injury (homicide)	There was concern from hospital staff with child returning to parents at time child was discharged that was not communicated to county DSS; parents were able to evade county DSS by moving back and forth between two counties
Carteret	Jesse Lee Willis	07/05/08	2yrs 5 months	Drowning by Asphyxia - Accidental	
Catawba	Adrian Lee Culp	10/01/09	3 weeks	Undetermined (co-sleeping/overlying suspected)	
Catawba	Kamden Lucas Harrington	11/23/09	10 months	Anoxic Brain Injury	Two prior assessments by DSS workers did not reveal an unsafe living environment, yet the medical report noted that the state of the child's room at the time of death was worrisome from chronic neglect and photographs of the overall residence depicted a living environment unsafe for children;
Catawba	Cody Ray Hudgins	07/07/12	5 yrs	Drowning	DSS prematurely closed a CPS assessment without determining the actual cause of a fire that was allegedly started on or near the bed of a minor child, including interviewing the fire marshal or requesting and reviewing the fire marshal's report.
Catawba	Dakyron D. Scott	04/26/11	2 yrs	Hanging - Accidental	
Catawba & Caldwell	Zahra Clare Baker	10/11/10	10 yrs	Homicide	
Cleveland	Jeremiah Ray Swafford	02/14/09	2 yrs	Blunt force head trauma due to physical assault/abuse	
Columbus	Ryan Chance Caulder	08/22/09	2yrs 3 months	Blunt Force Trauma to the Head (manner undetermined)	The family had interactions with both Lee and Columbus DSS. There were several breakdowns in communication which left both DSS agencies unaware of the interactions with the other agency.
Craven	Alanna Garris	02/22/13	6 yrs	Death by Motor Vehicle (accidental)	

County	Name	Date of Death	Age	Cause of Death	Case Notes
Craven	Cumuriya Cobb	01/20/09	1 yr	Subdural Hematoma - Homicide	During a visit in the child's home, it was learned that drug activity was going on within the home. Craven County Department of Social Services did not document this new information through a child protective services report. The criminal histories of the child's caretakers were not appropriately evaluated during the assessment. DSS did not recognize the significance of the mother's mental health and cognitive limitations. In addition, appropriate stakeholders were not consulted when assessing safety and risk to the children.
Cumberland	Joshua Arenivar	08/07/07	3 yrs	Blunt Trauma to the Head (homicide)	
Cumberland	Anijah Burr	03/27/06	3 yrs	Undetermined (homicide)	
Cumberland	Kaiden Demus	06/11/12	1 yr 3 months	Blunt Force Head Trauma (homicide)	Kaiden was originally referred for CPS based on allegations of substance abuse by parents and lack of proper supervision of Kaiden. Case was closed with no monitoring, parental restriction, or permanent plan put in place for Kaiden; the mother's capacity to parent and risk to Kaiden were never adequately assessed.
Cumberland	Melody Yvette Lilly	03/02/10	2 months 3 days	SIDS (natural)	
Cumberland	Georgina Nieves	08/06/14	6 weeks	Asphyxia due to Wedging	Georgina, who tested positive at birth for barbiturates, was born to a Mother with multiple mental health diagnoses and a long history of substance abuse; DSS risk assessment showed family's potential for future neglect was high, the mother was 38 weeks pregnant and did not receive a drug screen - the case was close - Georgina was born 2 weeks later.
Cumberland	Jade Alexander-Shaw	01/22/11	1 month	Asphyxia Secondary to Smothering - Accidental	
Cumberland	William Yates	07/31/10	1 yr 9 months	Blunt Force Traumatic Injuries to the Head, Chest, and Abdomen - Homicide	
Cumberland	Jaquial C. Renfro	04/17/11	16 yrs	Drowning	Only one of the three direct care staff of the facility assigned to Jaquial's cottage group on the day of the drowning was available to supervise the eight children in the cottage, which is contrary to the facility's policies. According to the facility's policy, children are not permitted to swim in the pond or swimming pool until after Memorial Day. The facility also requires all staff members who will be involved in the supervision of residents using the pond or swimming pool to complete a Water Safety Training course. The direct care staff with the children had not completed the course. Neither of these requirements was adhered to on the day of the incident
Dare	Joshua Benito Manzanares	08/27/07	6 months	Inflicted Traumatic Brain injury (homicide)	

County	Name	Date of Death	Age	Cause of Death	Case Notes
Davidson	Leala Dorothy Hardy	12/26/11	4 yrs	Mechanical Asphyxia - Accidental	The family was very transient throughout the life of the case and moved between three different counties on a regular basis. • Cross county Policy/Procedure continues to be vague and administered inconsistently across the one hundred counties relating to kinship care assessments. • There was some confusion among the counties regarding responsibilities in completing record and history checks on various family members.
Davidson	Carson Overby	04/29/10	15 yrs	Gunshot Wound to the Head - Suicide	Education and medical professionals recognized suicide risk factors in Carson and made appropriate referrals for follow-up services. There was no indication that services were sought or provided.
Duplin	Kayden Lee Davis	06/28/10	3 yrs 1 month	Drowning - Accidental	
Durham	Evan Fullard	02/18/13	28 days	Asphyxia due to Accidental Smothering	
Durham	Jaliya Sanai Galloway	05/22/09	7 weeks	Undetermined (no criminal charges)	
Durham	Hakeem Salaam	06/04/11	3 yrs 10 months	Anoxic Brain Injury due to Drowning - Accidental	
Durham	Nicholas "Tyler" Sepulveda	11/12/06	2 yrs	Undetermined (no criminal charges)	
Durham	Coriyana Hayes	04/15/14	3 months	he etiology of the decedent's elevated sodium was not identified during her hospital stay. Medical records noted that her hypernatremia was most consistent with exogenous sodium.	This child had a sibling who died in 2006 with the cause of death listed as sudden infant death syndrom. At the time of Coriyanna's death, other children in this family were a six year old, four year old, 2 year old twins and a 1.5 year old living away from the family home.
Durham	Aryannah A. Smith-Jones	07/22/11	16 months	Fentanyl Poisoning - Accidental	The case involves a minor mother who was not living in the home with her child at the time of the child's death. At the time of death, Aryannah was in the primary care of a relative who was using the prescribed pain medication, Fentanyl. During the child protective services assessment, Aryannah's mother had indicated several times her concern the relative was taking multiple medications and the potential impact on the caregiver's ability to care for the child.
Durham	Christian Pittman	04/28/14	9 yrs	shotgun wound to the left shoulder	During the last year of Christian's life. DSS received 3 CPS reports regarding this family. The last case was closed 4 months prior to the child's death. During these assessments, more contact should have been made with the family, no criminal records checks were completed on adults living in the home, no 911 checks were completed, and no medical exams were completed when bruising was present.

County	Name	Date of Death	Age	Cause of Death	Case Notes
Gaston	Addison Grace Lanham	06/09/09	2 yrs	Septicemia due to Medical Neglect - Homicide	Gaston County Probation Office was alerted that a sex offender was living with Addison, but no child protective services report was made to Gaston County DSS; In light of significant risk concerns in regards to the mother's history, there was an inadequate discharge plan when Addison and Shanna Lanham were release from labor and delivery; In both child protective services assessments, DSS did not fully grasp the impact of the mental health history, substance abuse issues and the prior child protective services history on the safety and risk to Addison; the Sheriff and Probation Officers were not contacted by DSS for collateral information;
Gaston	Marcus Hernandez	10/20/08	20 days	SIDS or Positional Asphyxia	
Gaston	Isabella Nealy	05/25/14	4 months	Undetermined	DSS did not understand extent of mother's substance abuse despite extensive contacts between multiple community agencies and family; DSS did not request Isabella's birth records; Isabella had a positive drug screen for marijuana and opiates at birth, and no child protective services referral was made to Gaston County Department of Social Services.
Gaston	Kaylob Dean Peek	03/05/09	13 days	Undetermined (probably SIDS)	
Gaston	Ashton Scott Saunders	10/30/09	4 months	Asphyxia due to Wedging Between Bed and Nightstand	Gaston County Department of Social Services identified issues needing more thorough evaluation in all three child protective services assessments but did not adequately follow up on: o The father's substance abuse which should have been explored further in light of his criminal history and the prior case documentation. o The mother requested mental health treatment subsequent to the 2009 assessment but there were no arrangements made for that treatment. o Given the lack of parental supervision secondary to substance abuse, the mother's assumed parental role in family should have been explored more fully in the assessments Timely transfer of the child protective services assessment case within the Gaston County Department of Social Services did not occur due to an insufficient tracking system.
Gaston	Brandon White	08/10/12	17 yrs	Asphyxia due to Hanging	Three behavioral health facilities documented child maltreatment concerning Brandon, but there were no child protective services referrals made to the local department of social services. On February 17, 2007, Cleveland County Department of Juvenile Justice had knowledge of child maltreatment, but there is no documentation that a report was made to the local department of social services or a request for Brandon to be examined at the hospital.

County	Name	Date of Death	Age	Cause of Death	Case Notes
Gaston	Davion Tyrome Alexander	08/14/10	19 days	SIDS or Suffocation	When the first report on Davion was received at the time of his birth, there were two safety plans developed with the family. However, there was a lack of a clear definition of approved supervision of Davion by adult relatives and approved supervision between Davion and the minor mother.
Guilford	Ambrosia Desena	02/19/09	15 yrs	Asphyxia due to Hanging	
Guilford	Micah Gibson Jr.	10/11/07	1yr 2 months	Blunt Trauma to Head and Torso; Burn in Left Axilla; Bronchopneumonia - Homicide	The gathering of additional information during (CPS) cases could have been beneficial in assessing actual risk, and subsequent case plans. Local DSS did not notify the local law enforcement agency following a CPS abuse report, which is protocol. Assessment tools were utilized, but did not reflect actual risk. The child was examined for concern of injury, and no medical record was obtained by local DSS.
Guilford	Shafonady Denny	02/18/14	10 months	Undetermined	
Guilford	Khan Lee Frazier	11/27/12	13 days	Blunt force trauma to the head and abdomen	
Guilford	Joseph Manning	11/24/11	13 yrs	Multiple Drug Toxicity	Guilford County Department of Social Services requested medical records from a mental health provider, but Guilford County Department of Social Services never received the records. The records document significant homicidal, suicidal ideations and substance use by Joseph and his caretakers, but there was no report made to a local department of social services, and the information was not considered within the case decision.
Guilford	Kali Brekia Martin	03/18/09	4 yrs	Blunt Force Head Trauma	Caretakers repeatedly were able to hide the children in the community and kept them out of school, which compromised the assessment of their injuries by medical and social workers. Children were out of contact from days to weeks at a time. After Surry County Department of Social Services was granted non-secure custody they placed the children with the paternal grandmother, who allowed the alleged perpetrators continued access to the children. There was an opportunity and a need for the caretakers to have parenting and a psychological assessment that was never requested. There was an allegation of sexual abuse that was never referred to Surry County law enforcement.
Guilford	Christian Welland Rook	02/02/10	17 yrs	Gunshot Wound to the Chest	Guilford County Sheriff's Department had information of an injurious environment in the home but did not report this information to Guilford County Department of Social Services. Despite a history of high risk violent behaviors potentially dangerous to himself and others resulting in a mental health commitment and an arrest, a safety plan was not developed with Christian while he was receiving outpatient therapy.
Guilford	Richard and Hanaleigh Suttles	11/21/11 & 11/25/11	16 yrs and 8 yrs	gunshot wound to the head - Homicide	

County	Name	Date of Death	Age	Cause of Death	Case Notes
Guilford	Terron Washington, Jr.	08/23/12	6 weeks	bronchiolitis.	Terron was residing in a foster home in Guilford County with his twin sibling. At the time of death, “this approximately 6-week-old male infant was reportedly found prone and unresponsive in his crib which was said to be shared with twin sibling” according to the Medical Examiner’s Report.
Guilford	Zyeon Samed-Harper Brooks	06/30/12	3 months	Asphyxial overlaying	There was medical history regarding an older sibling treated at a hospital for injuries that was not reported to Guilford County Department of Social Services.
Halifax	Josiyah Williams	10/08/14	3 months	Undetermined (premature 36 wks; tested positive for marijuana at birth)	The mother reported she did not know she was pregnant with Josiyah and did not receive prenatal care. This was her pattern with her past two pregnancies and this was her fourth child. Halifax County Child Protective Services (CPS) required the mother to receive substance abuse treatment in 2013 following the birth of another child, Jayceion, who was born positive for marijuana, 36 weeks gestation and low birth weight. CPS actively provided services to this family from August 18, 2013 until October 2, 2013. On 11/11/13, HCDSS was notified that mom had been discharged from the substance abuse program due to non-compliance
Harnett	Cameron Haley Kendall	11/26/08	15 yrs 8 months	Hydrocodone Intoxication	
Harnett	Jordan Judd	11/03/09	7 weeks	Mechanical Asphyxia due to Co-Sleeping with Adult - Accidental	
Harnett	Lariyah Merchison	09/19/10	29 days	complications of dehydration	
Harnett	Robi Williams	12/22/12	14 yrs	multiple drug toxicity/overdose	There was limited and ineffective communication among the agencies serving this child and family. Multiple agencies were involved with the child and family but there was not a primary point of contact to coordinate services. Robi had mental health and substance abuse needs which were identified. However, his needs were not met by the mental health system. Robi needed an out of home placement in a higher level of care but this was not immediately available.
Haywood	Tayla Rae Cabe	11/11/10	17 yrs	Oxycodone Poisoning	The team finds that insufficient care coordination between the service providers occurred, causing communication deficits both within individual agencies as well as between the service providers themselves which contributed to Tayla and her caretaker’s behaviors not being addressed. Agencies and service providers are tentative about sharing information due to HIPAA regulations, which impacted the communication between the agencies, contributed to the lack of coordination between the agencies/service providers.
Haywood, Macon & Jackson	Ashley Taylor	04/17/13	16 yrs	Self-Inflicted Hanging	Due to multiple local county department of social services involvement, the case history was sofragmented that without full disclosure from parties involved, discovery of all history would have been difficult.

County	Name	Date of Death	Age	Cause of Death	Case Notes
Iredell	Skylar B. Call	03/15/12	4 yrs	multiple blunt trauma injuries. - Automobile Accident	
Iredell	Dylan Menscer	06/23/12	7 yrs	closed head trauma - Accidental	
Johnston	Marquez Antonio Stanley	03/27/10	2 months 12 days	SIDS - natural	This medically fragile premature infant was born to a 25 year old single mom who had 5 children of the following ages: 3,4,5,6,9. The mother and children could have benefitted from available in-home services such as Child Service Coordination (now CC4C) and Parents as Teachers.
Johnston	King Isiah Walker	03/10/10	1 yr 2 months	Smoke Inhalation & Carbon Monoxide Poisoning - Accidental	
McDowell	Gavin Xavier Reel	12/31/09	3 yrs	Blunt Force Trauma to Head and Chest - Motor Vehicle Accident	
McDowell	Timberland Gage Reel	12/31/09	5 yrs	Blunt Force Trauma to Head and Chest - Motor Vehicle Accident	
McDowell	Aiden Ryder Williams	02/16/09	7 months	Aspiration Pneumonia due to Acute and Healing Head Trauma	
Mecklenburg	Kaleb Lowery	06/22/13	9 months	Amitriptyline and Diphenhydramine Toxicity - Homicide	There was an assessment completed on Charlene and Jerry Workman's home, but the assessment did not include information on Charlene's mental health needs, medical needs, or their capacity to parent. The mental health information could have been significant as support could have been provided to assist with parenting, as the family expressed concerns about the behavior of an older sibling in the home a week before Kaleb's death
Mecklenburg	Demytre Pendleton, Jr.	09/09/11	2 yrs 7 months	Hypoxic/Ischemic Encephalopathy due to Blunt Force Head Trauma and Probable Suffocation - Homicide	While medical staff stated that ongoing risk and safety of the child should be further investigated regarding the child's injuries, Mecklenburg County Youth & Family Services' documentation does not reflect ongoing assessment and investigation after the child was discharged from the hospital.
Mecklenburg	Devan James Seak	01/12/12	15 yrs	Quetiapine toxicity due to overdose	There were concerns in regards to Devan's care that warranted a child protective services referral made to Mecklenburg County Youth & Family Services. Instead of making the referral themselves, the state psychiatric hospital relayed the information to Devan's care manager. As a result, the information was never reported to Mecklenburg County Youth & Family Services.
Mecklenburg	Tiffany Ranae Wright	09/14/09	15 yrs	Gunshot Wound to the Head	

County	Name	Date of Death	Age	Cause of Death	Case Notes
Mecklenburg	Sincere Jaqoun Cellent	10/24/09	11 months	Drowning in bathtub	There were four Child Protective Services Assessments that did not capture the gravity and the impact of past CPS history in Pennsylvania, family violence of siblings, lack of parenting skills, mental health needs of the family and the ongoing domestic violence between the parents, and as a result: a. inconsistent/infrequent contact with the family was done; b. follow up with service providers was not maintained; c. a trauma assessment and a parenting capacity evaluation was not explored for the mother and other family members; d. information provided to the county attorney did not reflect the depth and scope of the case history; e. Structured Decision Making tools did not reflect historical and current case information, which could have framed social worker/supervisor consultations; f. The history of 911 calls for service was not requested on an ongoing basis; and g. appropriate domestic violence services were not arranged for the family.
Mecklenburg	Marcus Davis Jr	07/14/11	1 yr 9 months	abusive head trauma - homicide	There appeared to be a lack of comprehensive understanding of the dynamics and impact of domestic violence in assessing the risk to this child. Seven social workers and 4 social work supervisors were involved throughout the life of this case. While all had received some domestic violence training, none had received current training, “Child Welfare Practices for Cases Involving Domestic Violence” through the North Carolina Division of Social Services.
Mecklenburg	Josiah and Gabriel Hawthorne	02/28/10	2 yrs 4 months & 1 yr 2 months	smoke inhalation/carbon monoxide toxicity as a result of a house fire	The family had prior history regarding inappropriate supervision and improper care in another county, but this information was not promptly requested by Mecklenburg Youth & Family Services, and was not included in the decision making process during the child protective services assessment. The family's history of involvement with child protective services was not reviewed prior to making contact with the family and this information was not taken into consideration prior to making the case decision during the Mecklenburg Youth & Family Services' child protective services assessment.

County	Name	Date of Death	Age	Cause of Death	Case Notes
Mecklenburg	Iyana Stephens	04/18/10	5 months	Asphyxia due to Wedging	Charlotte Mecklenburg Police Department did not follow domestic violence protocol where officers had the obligation to file criminal charges. It was not documented that Charlotte Mecklenburg Police Department provided referral supportive services to the victim. Mecklenburg County Youth & Family Services child protective services assessment on the parents did not adequately reflect the depth and scope of family issues/needs individually and collectively. Additional resources (911 call for service to the home and urinalysis screening) were available but were not utilized. Utilizing these resources could have aided Mecklenburg County Youth & Family Services in their ability to provide a comprehensive assessment of the children and family and in the reassessment of the Out of Home Service Agreement. Information used in the psychological evaluation was primarily from the parents' self reports.
Mitchell	Ethan Travis Robinson	06/15/08	17 yrs	Methadone Toxicity	In 2007, Ethan was seen at Blue Ridge Regional Hospital emergency department following a four-wheeler accident. He had been given methadone by a caregiver prior to his arrival at the hospital. This was not reported to either DSS or law enforcement.
Montgomery	Filiberto Isiah Sanchez	05/24/09	3 months	Positional Asphyxia	FirstHealth Montgomery Memorial Hospital documented disclosures about acts of domestic violence resulting in physical injuries, but this information was never reported to the Sheriff Department or DSS. Troy Medical Services documented that the baby had an anomaly to his sternum possibly indicating injuries. Although a physical exam was completed on the child it was not documented whether this was a concern, therefore no follow up was done. Montgomery County Health Department had knowledge of domestic violence and mental health concerns of the family but did not report that information to DSS. The assessment completed by DSS did not capture the significance of the family of the mental health and domestic violence issues in the family. In addition, the child protective services assessment did not accurately reflect the importance of monitoring an infant that is diagnosed with failure to thrive. The older child's medical records indicated the same medical concerns as the victim child, but the child protective services assessment focused only on the medical needs of Filberto and did not address concerns of the older child. DSS acknowledges that the lack of staff experience impacted the ability to understand the complexities of doing a family child protective services assessment.
Moore	Jacy Henderson-Bullard	08/24/08	7 months	Acute Intra-Cranial Injury with Herniation/Cerebral Edema; Blunt Force Trauma to the Head with Skull Fracture	

County	Name	Date of Death	Age	Cause of Death	Case Notes
Moore	Caden Tyler Lindquist	09/25/10	16 months	Drowning - Accidental	When both parents were arrested and a second child protective service report was received on this family, Caden was placed by the parents with a family member in a safety resource placement, which was assessed by DSS and determined to be a safe placement for Caden. Two days after that placement was made, the family member informed DSS that other family members may be helping with Caden's care. The extent of this assistance from other family members was not fully assessed. Two days later, Caden drowned while staying at the home of another family member who was not assessed as a safety resource.
New Hanover	Mara Kathleen Calva	11/20/08	1 month 10 days	SIDS - natural	
New Hanover	Cody Glenn James	02/26/10	29 days	Undetermined/Co-Sleeping	
New Hanover	Alyssa Lewis	04/17/15	17 yrs	Suicide	
New Hanover	Jamiah Batts	02/29/12	9 yrs	Undetermined	
New Hanover	Bailee Long	12/05/12	10 months	Undetermined	
Onslow	Damien Brown	03/23/15	4 months	Undetermined	Throughout Onslow DSS's involvement with this family (prior to infant's birth), there were numerous allegations regarding Mom's substance abuse. However, the extent of Mom's substance abuse and how it can impact the care of children was never thoroughly assessed.
Onslow	Alexander James Froland	04/24/13	10 months	Drowning in Bathtub - Accidental	When Alexander was born, an Onslow County Department of Social Services social worker made a CPS referral June 28, 2012 regarding Alexander's birth into this family. The referral was not accepted for a CPS evaluation stating "no allegations, other children soon to be back in the home, completed all activities and done everything they were supposed to do." There is no evidence or documentation that suggests any professional from any agency (in a position to observe parental capacity) was in the Froland home during the ten months of Alexander's life. Conditions at his death suggest that the home environment and parent's elationship had deteriorated since the time that Onslow Department of Social Services was actively providing services to the family.
Onslow	Sadie Gates	09/27/10	1 yr 7 months	Drowning - Accidental	The two social workers assigned to the assessments had not attended any formal domestic violence training and were unable to thoroughly assess the risk factors in this family as they related to domestic violence.
Onslow	Julius Khalil Lewis Carter	04/29/11	2 yrs 45 days	closed head injury due to non-accidental injury	

County	Name	Date of Death	Age	Cause of Death	Case Notes
Onslow & Person	Dante' Joseph Diven	08/04/14	2 yrs 7 months	buprenorphine intoxication	Dante's mother, Ellen Brittany Green-Allen, was very transient throughout the life of the case and moved between three counties on a regular basis. The Onslow DSS, the Person DSS and a third DSS did not adequately utilize collaboration and effective communication during the course of the Child Protective Services assessments to ensure all available and pertinent information was shared.
Pasquotank	Lesselle Spencer	01/04/12	17 months	Undetermined	Lesselle had a biological sister who died in May of 2009 at 6 months of age 3 years earlier. Her cause of death was SIDS.
Pender	I'Mareon Wooten	01/13/10	3 yrs	Blunt Head Trauma due to Motor Vehicle Accident (no restraints)	Pender County Department of Social Services received 5 child protective services referrals on this family between February 2009 and January 2010. Pender County Department of Social Services received pertinent additional information on this case after normal operating hours in October of 2009. This information was documented but was not forwarded in writing to the assigned social worker. Throughout the span of this year and the course of 5 evaluations, the risk to this child was not adequately assessed.
Person	McKenzie Lynn Harper	05/17/12	1 month 8 days	Undetermined	
Pitt	Norman Donte Carter	11/16/12	10 months	Probable Cause Pending - child had a history of non-accident trauma	The kinship care assessment (DSS-5203) dated May 1, 2012 was completed and put in place before the social worker made a home visit or conducted any background checks on the relative to whom responsibility was assigned ensuring the primary caregivers were not left unsupervised with the children. Additionally, background checks were not completed on anyone else living in the relative's home. DSS authorized discharge to the home for the child based on this incomplete kinship care assessment
Pitt	Dakota Etheridge	06/07/10	5 months	non-accidental head trauma - homicide	Dakota's four older siblings had been legally removed from their mother's custody due to adjudicated abuse and neglect. They are now permanently placed in the custody of kin due to their mother's inability to safely care for them. This family had years of child welfare history with DSS and Dakota's siblings were receiving foster care services when he was born. There was no progress on the case plan to improve parenting skills or resolve substance abuse issues. In addition, Dakota's mother was hospitalized, while pregnant with Dakota, for a domestic violence related injury. Dakota was not screened for child protective services when he was born. DSS evaluated and changed intake practice regarding the screening of reports on newborns which includes reviewing relevant case history in determining whether a newborn is at risk and in need of a child protective services assessment.
Pitt	Ziitek Person	04/08/12	47 days	Asphyxia by Overlay - Accidental	
Randolph	Juan Corona	06/30/14	6 months	Complications resulting from being born addicted to opiates	

County	Name	Date of Death	Age	Cause of Death	Case Notes
Randolph	Katelyn Guerrero	01/25/11	6 months	asphyxia by smothering - Accidental	Katelyn was involved in child protective services in Randolph County and found deceased in an unsafe sleep situation in Wake County. Issues identified in case management included: o Lack of diligent efforts to locate the family, including issuing a CPS Alert when the family disappeared; o Insufficient documentation of services provided while Katelyn was in Randolph County
Randolph	Xavier Martinez	06/25/09	2 yrs	Peritonitis secondary to transaction of duodenum - Homicide	During the assessment, the parent's statements were accepted without verification by DSS staff. Such verification is critical in completing a thorough assessment. DSS staff did not obtain a full medical assessment of the injury to determine if the parents' statements were consistent with the injuries observed. In retrospect, the parents' statements were not consistent with how the injury could have occurred. DSS staff did not request medical records which could have been reviewed to determine if there was a pattern of injuries to the child. There were pertinent collaterals that had contact with the children that DSS staff did not interview. There was another child identified in the child protective services assessment for which DSS staff did not secure a medical exam to determine if there were any unexplained injuries present to that child.
Randolph	Corey Peak	06/29/10	3 yrs	Drowning - Accidental	Two 911 calls indicating the child was not being supervised properly were not reported to DSS. The Randolph County Department of Social Services child protective services assessment identified issues of supervision, but those issues were not addressed in the family case plan.
Randolph	Jessica Lynn Whitman	09/26/09	14 yrs	Amitriptyline Toxicity - Suicide	There was a lack of documentation in the DSS record of meaningful contact in the child's living environment for the two months prior to the child's death. DSS had identified unmet medical and mental health needs that remained unaddressed. Randolph County had insufficient contact with the child's non-custodial parent who was involved in the child's life to assure engagement in case planning for the child.
Richmond	Carson Barrett	11/17/11	2 yrs	Drowning - Accidental	
Robeson	Jay Flores	02/16/10	3 yrs 8 months	Drowning - Accidental	
Robeson	U'Ziah Kerns	07/03/14	17 days	Undetermined - probably overlay and suffocation	Mom lost custody and unsupervised visitation with her 2 year old child (in 2012) due to physical abuse of child. It was undetermined as to whether Mom or her Mom's boyfriend was perpetrator of this abuse. Mom's boyfriend, Father of this infant, was court ordered to have no contact with Mom's 2 year old child due to physical abuse of child. There was a 16 month old child in the home when this infant was born. Mom, primary caretaker, has a history of abuse/neglect as a child and was actually in the custody of Robeson DSS as a minor. There are allegations of domestic violence throughout the case. Both parents have criminal history.

County	Name	Date of Death	Age	Cause of Death	Case Notes
Robeson	Nathaniel Reed	11/22/10	17 months	blunt trauma of the head and abdomen - homicide	this child was seen by a local pediatric clinic on October 26, 2010 with an unexplainable bruise to the face and the pediatric clinic did not report this concern to DSS. Due to miscommunication during the Child Protective Services Intake process, this case was accepted as a family assessment for neglect with a 72 hour response time. This case was more appropriate for an investigative assessment for abuse with a 24 hour response time. DSS received a Child Protective Services referral on this child on May 4, 2012. The assessment determined Nathaniel was at low risk for future abuse and neglect and the case was closed on May 18, 2012. The risk to this child was not thoroughly assessed which skewed the risk rating. Nathaniel was eligible for, and could have benefitted from, in-home services. During contacts by Robeson Department of Social Services with this family on May 4, 2010 and November 1, 2010, the child's mother shared with the social worker that she had been in foster care. Despite this information, the caretaker's family history was not reviewed in assessing risk to this child which would have provided additional insight into the family dynamics.
Rowan	Jy'hime Bacon	02/14/09	2 months	Undetermined - Mother Pled No Contest to Involuntary Manslaughter	The mother had two infants to die in her care, and they both were left in unsafe sleep environments. Jy'hime Bacon's older brother Zy'marion Myers, who was born on October 13, 2007, died on November 11, 2007 at 29 days old. According to the North Carolina Medical Examiner's report Zy'Marion's cause of death was "Asphyxia due to Suffocation". There were no charges filed in the death of Zy'Marion. There is one surviving sibling.
Rowan	Daniel Safrit	09/27/13	11 yrs	asphyxiation due to hanging - suicide	
Rutherford	Bryson Clay Shell	04/24/09	3yrs 9 months	Blunt Force Trauma to the Head and Chest due to struck by vehicle	The mental health provider and probation officer was aware of the mother's substanceabuse usage, but did not report the information to DSS.
Rutherford	Jonathan Lee McSwain	12/23/09	17 yrs	Carbon monoxide toxicity due to smoke and soot inhalation	While DSS conducted a home visits with Jonathan and his mother there was no documentation that an assessment done of the home environment was completed when the mother and her partner moved to a new home. Despite concerns of the child's safety within the mother's home, the level of community services from the Guardian Ad Litem and mental health providers were decreased.
Stanly	Navaeh Tyson	07/05/11	2 yrs	Head trauma/Brain Injury and open skull fracture as a result of being struck by vehicle - Accidental	
Swain	Caden Jayce Lossie	05/19/12	25 days	Undetermined	

County	Name	Date of Death	Age	Cause of Death	Case Notes
Transylvania	Kortni Marie Denise Spears	10/30/09	17 yrs	Subacute necrotizing leukeoencephalipathy, hypoxic ischemic brain injury, and tonsillar herniation - Accidental	Kortni had repeated trips to the Transylvania County Emergency Department but a drug assessment was not completed during those visits. Kortni disclosed to a mental health provider that she was sexually abused which was not reported to DSS or a law enforcement agency. One DSS was aware of behavioral concerns with Kortni and that her mother was seeking out of home placement through Eckerd Camp. The child protective services assessment was closed without assuring the services were in place. A second DSS had an open Child Protective Services In Home Services case in which there were numerous identified risks. The services arranged did not fully address those concerns. Transylvania DSS was aware the family was receiving therapy services through Families Together and that Kortni was on Juvenile Probation. The Child Protective Services assessment was closed without ensuring that Mental Health services were effective or whether Kortni was complying with the conditions of probation.
Union	Lucas Enrique Blount	04/09/14	17 yrs	Gunshot wound to the head	Continuity of therapeutic care for Lucas was never established, it was fragmented. None of the services providers involved with Lucas requested a comprehensive clinical assessment to identify risk, strengths, needs and recommendations. A comprehensive clinical assessment would have provided information of Lucas first suicide attempt. There were multiple instances in which information was not fully disclosed or assessed between all those persons and agencies involved with Lucas life. While a Child & Family Team is not required in Child Protective Services assessments, Lucas' multiple needs (substance use, criminal charges, and mental health) warranted service providers to convene to address the identified needs Lucas and his support system. Department of Juvenile Justice in Union County was aware Lucas had treatment needs, but they did not assure the service provider selected was certified to provide an adequate assessment and deliver treatment. The Department of Juvenile Justice and DSS did not fully connect and collaborate on addressing needs. DSS assessments did not adequately identify Lucas' risk and safety needs because: o pertinent collaterals (the Department of Juvenile Justice, school personnel, Probation & Parole, mental health and Law Enforcement) were not contacted for additional information; o social workers did not holistically assess the case when involved; o social workers did not request, review and consider all medical information; o structured decision making tools were not reflective of the case history; and, o there was no indication that supervisory oversight was purposeful. Child protective services social workers acknowledged the agency was experiencing high caseloads and was under pressure to close child protective services cases. There was an impression by DSS and the Department of Juvenile Justice in Union County that the therapeutic services provider was delivering intensive in-home services. There was no safety planning surrounding suicidality. There was no clear documentation that Lucas' case had been closed between the therapeutic provider and DSS.

County	Name	Date of Death	Age	Cause of Death	Case Notes
Wake	Lareq Izaiah Lamar Watkins	06/18/09	1 month	Undetermined	
Wake	Jrue Morant	10/08/13	1 yr	aspiration pneumonia due to neurologic impairment with severe cerebral and cerebellar atrophy due to non-accidental head injury - Homicide	
Wake	Joshua Callahan	09/26/12	2 yrs 9 months	asphyxia and smothering - Homicide	Joshua Callahan was killed by his Mother who was mentally ill. Pertinent history regarding his Mother's mental illness was in Child Protective Services case history with Harford County, Maryland. Joshua was open for Child Protective Services in 2 North Carolina counties (one county for 4 months and Wake County for 3 months). Neither county was aware of prior Child Protective Services history in Maryland. Therefore, this history was not incorporated into the assessments when determining risk to Joshua. Joshua's Mother verbalized "fear of Child Protective Services" and moved frequently. She lived in Maryland, Florida and North Carolina during Joshua's short life. This case was open for Child Protective Services (CPS) in Rockingham County from November of 2010 until February 2011. During this assessment, medical records were obtained from Upper Chesapeake Medical Center in Maryland. The request to the Medical Center was for "any and all records." However, the Medical Center forwarded medical records only. The medical records did not document the fact that a CPS referral was made to Harford County DSS when Joshua was 1 day old. Due to the Mother's mental illness and instability, Joshua was immediately taken into custody by Harford County DSS. Joshua Callahan was referred for Child Protective Services in Wake County on June 28, 2012. An initial visit was made with Joshua and his Mother on June 29, 2012 when they were relocating from one motel to another. A collateral contact told Wake DSS that Joshua's Mother was "afraid of CPS" and had relocated to another county. When Wake County DSS attempted to contact this family for follow up, they were unable to locate her. A Wake County computer search "benefits check" did not reveal that the Mother was continuing to live and receive financial and child care services in Wake County. The case was closed, without further contact with this family, in September of 2012.
Wake	Christopher Scott Childers Jr.	02/05/12	6 months 2 days	complications of non-accidental head injury - Homicide	
Wake	Derrick Lamont Scott	01/29/12	16 yrs 5 months	multi-organ failure - Accidental	
Wake & Onslow	Autumn Naimi	10/11/09	3 months	undetermined with pulmonary valvular stenosis and hypothyroidism listed as contributing conditions	The mother of this child spent most of her life in foster care. Throughout her life, she experienced multiple placements (15+), several psychiatric hospitalizations and a lack of continuous mental health care. Autumn was her fourth child and the only child she had in her care. Two children were in the care of a relative and one child was released for adoption. The lack of stability in foster care appeared to impact her ability to effectively bond with and parent her children.

County	Name	Date of Death	Age	Cause of Death	Case Notes
Wayne	Jamaj Jasir Lewis	04/04/10	3 weeks	Dehydration	
Wayne	Reginae Fields	06/06/14	3 yrs 9 months	probable asphyxia	Reginae Fields was initially referred to Child Protective Services (CPS) on September 22, 2010. She was most recently referred to CPS on May 11, 2014. The case opened for CPS services on May 11, 2014 and remained open when the child died. During this time, there was insufficient contact with the family and gathering of collateral information in order to thoroughly assess risk to this child and her sister.
Wayne	Matthew Theurer	02/15/13	1 yr 2 months	Malnutrition - Homicide	Wayne County DSS and Seymour Johnson FAP were actively working together with this family prior to case closure in June of 2012. When child returned to live with the father, Wayne County DSS was not notified that child was back in the home with the father.
Wilkes	Caleb Joe Tipton	08/29/07	4 months	suffocation by plastic bag	Another County DSS conducted an assessment in response to a child protective services report in which: o History was not secured and considered prior to the case decision. o Input from the Wilkes County DSSregarding the Child's protective services history was not adequately taken into account in making the case decision. During the course of the child placement case, Wilkes County DSS maintained an insufficient level of contact with the family. In addition, persistent and diligent efforts were not make to engage parents in case planning. The Wilkes DSS and the second DSS did not adequately utilize community partners for communication and collaboration during the course of the child protective services assessment and child placement case to ensure all pertinent information was made available. The Wilkes DSS had knowledge that the parents were known to alter drug screens while utilizing drug testing methods at the time. The mother acknowledged drug use during previous pregnancies with her older children and this is documented in the social services' case dictation and the Adjudication/Disposition Order.
Wilkes	Benjamin Paul Bradford Brawley	04/27/10	17 yrs	acute morphine intoxication - Accidental	The child did not receive adequate treatment for dealing with substance abuse and persistent exposure to chronic mental health issues. A recommendation for Level III placement from his placement provider and a psychologist was not considered prior to the release of legal custody from DSS.