Child Fatality Report Release of Information to the Public

Person ID: 108913796

County of Child's Residence: BELL

Gender: Female

Age: 1 Year(s) 0 Month(s)

Date of Death: 09/29/2022

On the date of the fatality, the child was not in DFPS conservatorship and was living with the child's parent, a managing conservator, a legal guardian or other person entititled to the child's possession.

Child's Name: Hartman,Na'Liyah H

Current Report(s) of Abuse/Neglect:

Intake Date(s): 09/28/2022

Summary of Allegation(s)/Investigation:

The Department received a report notifying that a one-year-old child was taken to the hospital after being found unresponsive due to possibly ingesting pills. A second report was received that the child died after being taken to the hospital and it was unknown who owned the pills or who was supposed to be supervising the child at the time.

The Department's investigation determined that the deceased child was taken to a hospital and was stabilized and the child was transferred to a different hospital. Life saving measures were continued, but were unsuccessful. The Department spoke with the parents of the deceased child and an unrelated household member. It was determined that the deceased child's father and the unrelated household member left the home at 5:00AM that morning to go to work. The deceased child and the deceased child's siblings were not awake at that time. The deceased child's mother and children woke up between 10:00AM-10:30AM. They ate breakfast around 11:00AM and the children began playing in the bedroom. The deceased child's sibling notified the mother around 2:20PM that the deceased child was "dead" and the mother found the deceased child gasping for air and emergency services were contacted. Various prescription pill bottles were located in the home by law enforcement, including pill bottles on the floor in the room where the children were playing.

The deceased child's siblings stated that the mother was asleep during the time that they accessed the pills from a

top shelf on the closet and took them. The mother was unable to account for her activities between 11:45AM-2:20PM. The unrelated household member stated that he had advised the parents the day prior that the children had a medication bottle. The home was seen to have various items on the floors, including scissors and an alcohol bottle.

Law enforcement conducted an investigation. No arrests have been made.

The medical examiner autopsied the deceased child and the final autopsy listed the cause of death as accidental and the manner of death as toxic effects of pseudoephedrine.

Investigation Findings:

The Department confirmed the allegation that the deceased child's mother committed neglectful supervision of the deceased child, which led to the child's death. The deceased child's mother was unable to account for her activities during the timeframe that the children were able to access the medications and the deceased child ingested them. The deceased child's mother did not secure unsafe items in the home such as medications, scissors, alcohol bottles, and various items located on the floor.

The Department confirmed allegations that the deceased child's father committed neglectful supervision because there were unsafe items in the home that were not secured.

The Department could not confirm the allegation that the unrelated household member committed neglectful supervision of the deceased child. The unrelated household member was not present at the time of death and was not responsible for the care of the deceased child.

Safety and Risk Assessment Factors Identified:
09/29/2022 Safety - Initial: Unsafe
10/18/2022 Risk: Moderate

Safety and Risk Assessment Factors Identified:

Case Action:

Close

Services and Referrals Provided to the Family:

Counseling and Evaluation,Parent/Caregiver Training

Other Services:

The referrals were accepted by the family.

Other Actions Taken to Mitigate Risk:

The deceased child's siblings were removed from the custody of the parents. The judge ordered that the children be placed with an out-of-state relative at the adversary hearing and the legal case was dismissed.

If one or more children were previously removed from the home, for each conservatorship episode, summarize dates of conservatorship and type of placement at the end of conservatorship:

Other Previous Report of Abuse/Neglect:

Intake Date(s):

Summary of Previous Allegation(s)/Investigation:

The Department requested an out-of-state CPS history check from the Oklahoma Department of Human Services on 09/20/2022. No response was received. The parents of the deceased child confirmed that the children had previously been involved with Oklahoma DHS and were removed from their care.

Investigation Findings:

Safety and Risk Assessment Factors Identified:

Case Action:

Services and Referrals Provided to the Family:

Other Services:

Other Actions Taken to Mitigate Risk:

Note: This report was prepared on 10/20/2023 and does not include corrections or updates, if any, that may be subsequently made to DFPS data on or after the date this report was prepared.