Child Fatality Report Release of Information to the Public

Person ID: 90534561

County of Child's Residence: TARRANT

Gender: Female

Age: 5 Year(s) 7 Month(s)

Date of Death: 07/28/2022

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: Parramore,Kayla

Current Report(s) of Abuse/Neglect:

Intake Date(s): 07/29/2022

Summary of Allegation(s)/Investigation:

The Department received a report about a fatality event where the five year old deceased child was found unresponsive in her maternal aunt's home. The maternal aunt was the deceased child's guardian. The deceased child had diabetes and had not been feeling good for a couple of days. The deceased child had not been eating but was drinking juice and Pedialyte. The maternal aunt did not take the deceased child to the doctor but said she was keeping an eye on her. The deceased child went to sleep around 5:00pm and the maternal aunt and others were checking on the child. Around 8:45pm, the deceased child was lifeless and the materal aunt drove the deceased child to the hospital. The doctor took the deceased child's temperature and it was 93 degrees. The doctor thinks the deceased child passed before arriving to the hospital.

The Department's investigation determined the deceased child had been diagnosed with a rare form of childhood diabetes that required specialized training and continual monitoring. The maternal aunt was the deceased child's legal guardian, and had been trained to meet the deceased child's medical needs. The deceased child had been sick for at least 24 hours prior to her death. The deceased child had been vomiting, fatigued, urinating on herself, thirsty, had generalized weakness, and was eventually found unresponsive in the maternal aunt's home. Law enforcement retrieved data from the deceased child's glucose monitor which revealed the deceased child's glucose levels had been so high the monitor could not accurately read her levels. The maternal had been educated on seeking medical

treatment if the deceased child exhibited these symptoms. The maternal aunt reported she had been monitoring the deceased child at home. The maternal aunt reported the deceased child had exhibited these symptoms before, she thought it would pass, and she didn't seek medical care. The maternal aunt has a history of missing medical appointments for the deceased child, and medical staff reported that the delay in the aunt seeking medical care resulted in the child's death. The Department consulted with child abuse medical professionals from the Forensic Assessment Center Network about the medical neglect. It was found that all children with diabetes are at an elevated risk of death, but with monitoring and appropriate medical care most episodes of ketoacidosis are manageable. Medical professionals reported that the child's death was highly concerning for medical neglect and the aunt should have sought care for the deceased child as soon as she started vomiting.

The medical examiner conducted an autopsy and the child's cause of death was determined to be diabetic ketoacidosis, and manner of death was ruled as natural.

The law enforcement investigation was pending at the time the Department's investigation closed.

Investigation Findings:

The Department confirmed that the deceased child's maternal aunt committed Medical Neglect of the deceased child, which led to her death. The aunt was aware of the deceased child's specialized medical needs, she was aware the child was sick, and she failed to seek reasonably appropriate medical care.

Safety and Risk Assessment Factors Identified:
Safety Assessments:
1.) 07/29/2022: Safety Assessment - Initial: Safe
2.) 11/22/2022: Safety Assessment - Case Closure: Safe
Risk Assessment Final Risk Level: Very High

Safety and Risk Assessment Factors Identified:

Case Action:

Close

Services and Referrals Provided to the Family:

Other Services:

No additional services.

Other Actions Taken to Mitigate Risk:

No additional action was taken.

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:

The deceased child and the deceased child's sibling were legally removed from their biological parents on 08-18-17, and the Department was granted temporary managing conservatorship. The children were placed in the care of their maternal aunt on 05-25-18. Permanent managing conservatorship was given to the maternal aunt on 07-18-18.

Previous Report of Abuse/Neglect:

Intake Date(s): 12/09/2016

Summary of Previous Allegation(s)/Investigation:

The Department received a report with concerns that the deceased child and the deceased child's sibling were in the care of their biological mother. There were concerns that the deceased child was hospitalized due to diabetes, and was receiving treatment for hyperglycemia. The mother was described as delayed , she was not able to read well, and had a hard time communicating. The mother has a history of medical and mental health issues, and there were reported concerns the mother was abusing prescription medications.

The Department's investigation determined the mother had a prescription for pain medication, and medical staff denied concerns the mother was abusing medication. The deceased child will have ongoing medical needs that require treatment and monitoring. The maternal grandmother was assisting in ensuring mother is taking medication as prescribed.

Investigation Findings:

The Department did not confirm that the deceased child's mother committed Neglectful Supervision of the deceased child. The maternal grandmother monitors the mother's medication and the mother's doctor denied concerns the mother was abusing the medication.

Safety and Risk Assessment Factors Identified:
Safety Assessments:
1.) 12/12/2016: Structured Decision Making Safety Assessment - Initial: Safe
2.) 12/19/2016: Structured Decision Making Safety Assessment - Reassessment: Safe with plan

Risk Assessment Final Risk Level: High
Case Action:
Family Preservation

Safety and Risk Assessment Factors Identified:

Case Action:

Family Preservation

Services and Referrals Provided to the Family:

Basic Needs Support

Other Services:

The family accepted services.

Other Actions Taken to Mitigate Risk:

The family agreed to work services with the Department through Family Based Safety Services. Services were provided to the family from 12-30-16 until 02-27-17. The family engaged in services for the mother's mental health, the deceased child's medical care, and the family had a family based support system at the close of the Department's case.

Previous Report of Abuse/Neglect:

Intake Date(s): 01/28/2017

Summary of Previous Allegation(s)/Investigation:

The Department received a report with concerns for the deceased child and the deceased child's sibling while in the care of their biological mother. There were reported concerns of domestic violence between the mother and the maternal grandmother occurring in the presence of the children. There were reported concerns that the mother abused her medication and was not caring for the children.

The Department's investigation determined the children were in another room sleeping when an altercation between the mother and grandmother occurred. The mother had a prescription for pain medicine. The mother had a prescription for Alprazolam, she was missing a week's worth of pills, and had no explanation. The mother and maternal grandmother remained in the home together. There was a nurse at the home for approximately 12 hours a day providing care for the deceased child.

Investigation Findings:

The Department did not confirm that the deceased child's mother committed Neglectful Supervision of the deceased child. The deceased child was in another room when the altercation between the mother and grandmother occurred. The mother had missing medication and was unable to account for the medication.

Safety and Risk Assessment Factors Identified:
Safety Assessments:
1.) 01/29/2017: Structured Decision Making Safety Assessment - Initial: Safe with plan
2.) 02/13/2017: Structured Decision Making Safety Assessment - Case Closure: Safe
Risk Assessment Final Risk Level: High

Safety and Risk Assessment Factors Identified:

Case Action:

Close

Services and Referrals Provided to the Family:

Other Services:

No additonal services.

Other Actions Taken to Mitigate Risk:

The family was receiving services through Family Based Safety Services during this investigation, the family remained cooperative with services, and there was no additional action taken.

Previous Report of Abuse/Neglect:

Intake Date(s): 05/12/2017

Summary of Previous Allegation(s)/Investigation:

The Department received a report with concerns for deceased child in the care of her mother and father. There were reported concerns the deceased child was born with an extremely rare condition and was in the hospital for a couple of months after birth. The deceased child was born with diabetes, it presented in its worst form, and is often fatal. The deceased child was on an insulin pump and requires a high level of care. There were concerns the parents had been noncompliant with the deceased child's medical needs and missed appointments. There were reported concerns the deceased child was prenatally exposed to the mother's drug use.

The Department's investigation determined medical professionals had concerns that the mother had not been consistent with the deceased child's medical needs and appointments. The deceased child had a severe medical condition that required ongoing medical treatments and a high level of care. The deceased child's father did not reside in the home and was not the primary caregiver. There were no concerns the deceased child was physically abused by the mother. The reported concerns of the mother's drug use were addressed in prior investigation.

Investigation Findings:

The Department confirmed that the deceased child's mother committed Medical Neglect of the deceased child. The mother had not been consistent with the deceased child's medical needs and appointments. The deceased child had a severe medical condition that required ongoing medical treatments and a high level of care.

The Department did not confirm that the deceased child's mother and father committed Neglectful Supervision of the deceased child. The father did not live in the home and the reported concerns with the mother's drug use were addressed in prior investigations.

The Department did not confirm that the deceased child's mother committed Physical Abuse of the deceased child. The deceased child didn't have any injuries and there were no concerns of physical abuse.

The Department did not confirm that the deceased child's father committed Medical Neglect of the deceased child. The deceased child's father did not reside in the home and was not the primary caregiver.

Safety and Risk Assessment Factors Identified:
Safety Assessments:
1.) 05/15/2017: Structured Decision Making Safety Assessment - Initial: Safe with plan
2.) 06/21/2017: Structured Decision Making Safety Assessment - Reassessment: Safe with plan

Risk Assessment Final Risk Level: Very High

Safety and Risk Assessment Factors Identified:

Case Action:

Family Preservation

Services and Referrals Provided to the Family:

Counseling and Evaluation,Basic Needs Support

Other Services:

The family accepted services.

Other Actions Taken to Mitigate Risk:

The family agreed to work services with the Department through Family Based Safety Services. Services were provided to the family from 06-22-17 until 10-10-17. The Department conducted a subsequent investigation during the Family Based Safety Services case, and the deceased child and the deceased child's sibling were removed. The Department obtained temporary managing conservatorship of the deceased child and deceased child's sibling on 08-18-17.

Previous Report of Abuse/Neglect:

Intake Date(s): 07/11/2017, 08/14/2017

Summary of Previous Allegation(s)/Investigation:

The Department received two reports during the open Family Based Safety Services case with the deceased child's family. On 07-11-17, a report was received with concerns the mother missed medical appointments for the deceased child. A second report was received on 08-14-17, with concerns the mother and the maternal grandmother continued to miss medical appointment for the deceased child.

The Department's investigation determined the mother took a drug test and was positive for Barbiturates, Hydrocodone, Hydromorphone, and Oxymorphone. The father took a drug test and was positive for Hydrocodone, and Hydromorhone. Neither parent had a prescription for any of the medications. The maternal grandmother had multiple prescription drugs and there were concerns the parents and the grandmother were abusing the grandmother's medication. The parents and grandmother were observed to be under the influence of prescription drugs that impaired their ability to effectively care for the children. Nursing staff had concerns regarding the supervision of the children and concerns that the family continued to miss the deceased child's medical care. A meeting was held to discuss the concerns in the home, but no relative was identified for placement. The children were removed and placed in foster care.

Investigation Findings:

The Department confirmed that the deceased child's mother and maternal grandmother committed Medical Neglect of the deceased child. The mother and grandmother had knowledge of the deceased child's medical issues and missed medical appointments.

The Department confirmed that the deceased child's mother and maternal grandmother committed Physical Neglect of the deceased child. There were concerns with the home environment including an infestation of bed begs and concerns the deceased child was left in a dirty diaper and was unclean.

The Department confirmed that the deceased child's mother, father, and maternal grandmother committed Neglectful Supervision of the deceased child. There were concerns with the mother, father, and maternal grandmother abusing medications and being under the influence while caring for the deceased child.

Safety and Risk Assessment Factors Identified:
Safety Assessments:
1.) 07/14/2017: Structured Decision Making Safety Assessment - Initial: Safe with plan
Risk Assessment Final Risk Level: Very High

Safety and Risk Assessment Factors Identified:

Case Action:

Removal/Subcare

Services and Referrals Provided to the Family:

Counseling and Evaluation

Other Services:

Services were provided through the legal removal of the children. Services were accepted.

Other Actions Taken to Mitigate Risk:

The deceased child and the deceased child's sibling were removed. The Department obtained temporary managing conservatorship of the children.
The mother and father did not complete services and lacked adequate parenting skills and abilities to care for the children's basic needs on a day to day basis without ongoing continual help. The maternal aunt was granted permanent managing conservatorship of the deceased child and the deceased child's sibling on 7/18/2018.

Previous Report of Abuse/Neglect:

Intake Date(s): 03/07/2019

Summary of Previous Allegation(s)/Investigation:

The Department received a report with concerns of the deceased child having access to her mother. The deceased child was previsouly removed from her mother's care due to lack of medical care and concerns that the mother abused drugs. There were reported concerns the deceased child was visiting her mother, who was not monitoring the deceased child's diet; and the deceased child returned from her mother's care with high sugar levels.

The Department's investigation determined the mother denied being alone with the deceased child in her care, she reported she sees the deceased child at the maternal aunt's home, and the mother never feeds the deceased child. The maternal aunt reported she has taken the deceased child to the mother's, she has left the mother and child alone a few times, and the aunt prepares the deceased child's meals when she takes her to the mother. The maternal aunt agreed not to allow the mother to have unsupervised contact with the deceased child in the future.

Investigation Findings:

The Department did not confirm that the deceased child's mother committed Medical Neglect of the deceased child. The mother denied feeding the child and the aunt reported she prepared the child's meals.Safety and Risk Assessment Factors Identified:

Safety Assessments:
1.) 03/12/2019: Structured Decision Making Safety Assessment - Initial: Safe with plan
2.) 04/24/2019: Structured Decision Making Safety Assessment - Case Closure: Safe

Risk Assessment Final Risk Level: Low

Safety and Risk Assessment Factors Identified:

Case Action:

Close

Services and Referrals Provided to the Family:

Other Services:

No additional services.

Other Actions Taken to Mitigate Risk:

No additional action was taken.

Previous Report of Abuse/Neglect:

Intake Date(s): 09/01/2020

Summary of Previous Allegation(s)/Investigation:

The Department received a report with concerns of the deceased child's medical needs not being met by the maternal aunt. There were reported concerns the deceased child was followed by the endocrinology clinic for Type 1 diabetes. There were concerns the aunt was no-showing appointments, and medcal staff have not been able to reach the family by phone. There were concerns the deceased child missed appointments with their primary care physician as well.

The Department's investigation determined the maternal aunt did miss the deceased child's doctor appointments. The maternal aunt had the insulin and the Omnipod which are required medical needs for the deceased child. The aunt was knowledgeable on how to use the Omnipod and when to administer insulin. Doctor appointments were rescheduled for the deceased child. There were no concerns noted from the primary care physician.

Investigation Findings:

The Department did not confirm that the deceased child's maternal aunt committed Medical Neglect of the deceased child. The aunt had the medicine and items needed to meet the deceased child's medical needs.

Safety and Risk Assessment Factors Identified:
Safety Assessments:
1.) 09/02/2020: Safety Assessment - Initial: Safe

Risk Assessment Final Risk Level: Moderate

Safety and Risk Assessment Factors Identified:

Case Action:

Close

Services and Referrals Provided to the Family:

Other Services:

No additional services

Other Actions Taken to Mitigate Risk:

No additional action was taken.

Previous Report of Abuse/Neglect:

Intake Date(s): 05/28/2021

Summary of Previous Allegation(s)/Investigation:

The Department received a report with concerns of the deceased child's medical needs not being met by the maternal aunt and maternal uncle. There were concerns the deceased child was last seen in person at the diabetic clinic on October 28, 2019, and the uncle brought the deceased child to that appointment. There were several canceled appointments and no shows before that appointment. The deceased child was scheduled for checkups every 4-6 months and missed several appointments. Attempts were made to reach the family without success.

The Department's investigation determined the maternal aunt did miss doctor appointments for the deceased child but she had the insulin which was required for the deceased child. The maternal aunt was knowledgeable on when to administer insulin and what the deceased child's levels should be. The maternal aunt was not aware of the deceased child's 05/24/2021 appointment being face to face. The aunt rescheduled the deceased child's face to face doctor's appointment in a location convenient for the family. The Department confirmed the appointment. The maternal aunt and uncle got a divorce. The uncle does not live in the home and was not a caregiver to the deceased child.

Investigation Findings:

The Department did not confirm that the deceased child's maternal aunt and maternal uncle committed Medical Neglect of the deceased child. The aunt had the medicine and items needed to meet the deceased child's medical needs. The uncle doesn't live in the home and was not a caregiver to the child.

Safety and Risk Assessment Factors Identified:
Safety Assessments:
1.) 05/28/2021: Safety Assessment - Initial: Safe
2.) 06/07/2021: Safety Assessment - Reassessment: Safe

Risk Assessment Final Risk Level: Moderate

Safety and Risk Assessment Factors Identified:

Case Action:

Close

Services and Referrals Provided to the Family:

Other Services:

No additional services

Other Actions Taken to Mitigate Risk:

No additional action was taken.

Previous Report of Abuse/Neglect:

Intake Date(s): 01/06/2022

Summary of Previous Allegation(s)/Investigation:

The Department received a report with concerns of the deceased child's medical needs not being met by the maternal aunt. There were reported concerns the deceased child started to get sick on 01/02/22 and the deceased child was vomiting and having abdominal pain. On 01/05/22, the deceased child started displaying an altered mental status and she was groggy and out of it. The maternal aunt took the deceased child to the hospital on 1/5/22. The deceased child was transferred to a children's hospital for more specialized treatment. The deceased child had hyperglycemia and she was very ill. One doctor said that her diabetes is doing exactly the opposite of what it needs to be doing. The deceased child tested negative for COVID-19 at the initial hospital and the children's hospital wanted to retest the deceased child for COVID-19. The maternal aunt refused the testing, checked the deceased child out of the hospital, and the aunt reported she was taking the deceased child to another hospital. The maternal aunt has a history of non-compliance with follow up with the deceased child's endocrinologist.

The Department's investigation determined the maternal aunt took the deceased child to a different child's hospital. The deceased child was seen and treated at the hospital. The maternal aunt understood the deceased child's diabetes and ensured her needs were met.

Investigation Findings:

The Department did not confirm that the deceased child's maternal aunt committed Medical Neglect of the deceased child. The aunt took deceased child's to the hospital to medical care. The maternal aunt understood the deceased child's diabetes and ensured her needs were met.

Safety and Risk Assessment Factors Identified:
Safety Assessments:
1.) 01/06/2022: Safety Assessment - Initial: Safe

Risk Assessment Final Risk Level: Moderate

Safety and Risk Assessment Factors Identified:

Case Action:

Close

Services and Referrals Provided to the Family:

Other Services:

No addtional services

Other Actions Taken to Mitigate Risk:

No additional action was taken.

Previous Report of Abuse/Neglect:

Intake Date(s): 05/26/2022

Summary of Previous Allegation(s)/Investigation:

The Department received a report with concerns of the deceased child's medical needs not being met by the maternal aunt. There were reported concerns there were orders from the children's endocrinology on how to care for the deceased child. The deceased child had not been to the clinic since January 2022. The family didn't notify the school that the deceased child changed doctors. The deceased child was now a patient at another children's clinic. The family choose to take the deceased child home from school instead of bringing the correct items needed for the deceased child's diabetic care at school. There were concerns the deceased child was hyperglycemic at school. There was concern the family still wasn't taking adequate care of the deceased child at home. On 5/26/2022, the deceased child's monitor was checked and her blood sugar hasn't been checked since around 6:00pm on 5/25/2020. The maternal aunt picked up the deceased child from the school because the school didn't have the new orders from the hospital to care for the deceased child's diabetes at the school. There were reported concerns the maternal grandmother was seen almost giving the deceased child the wrong amount of insulin until she was stopped and told the correct amount.

The Department's investigation determined the reported concerns were previously addressed in the last investigation that was closed in February 2022. Medical records were received for the deceased child from the clinc the child was currently attending. The deceased child was seen by endocrinology on 04/27/2022, and new orders were given for insulin with the same prescriptions and dosages as the child's prior doctor. The family changed medical providers for the deceased child and there are no concerns noted for the child.

Investigation Findings:

The Department did not confirm that the deceased child's maternal aunt committed Medical Neglect of the deceased child. The concerns were addressed in a prior investigation and the family changed medical providers for the deceased child and the child.

Safety and Risk Assessment Factors Identified:
Safety Assessments:
1.) 05/27/2022: Safety Assessment - Initial: Safe
Risk Assessment Final Risk Level: Risk Assessment not required by Policy.

Safety and Risk Assessment Factors Identified:

Case Action:

ADMIN - Already Investigated

Services and Referrals Provided to the Family:

Other Services:

No additional services

Other Actions Taken to Mitigate Risk:

No additional action was taken.

Other Previous Report of Abuse/Neglect:

Intake Date(s):

Summary of Previous Allegation(s)/Investigation:

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 05/05/2023 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.