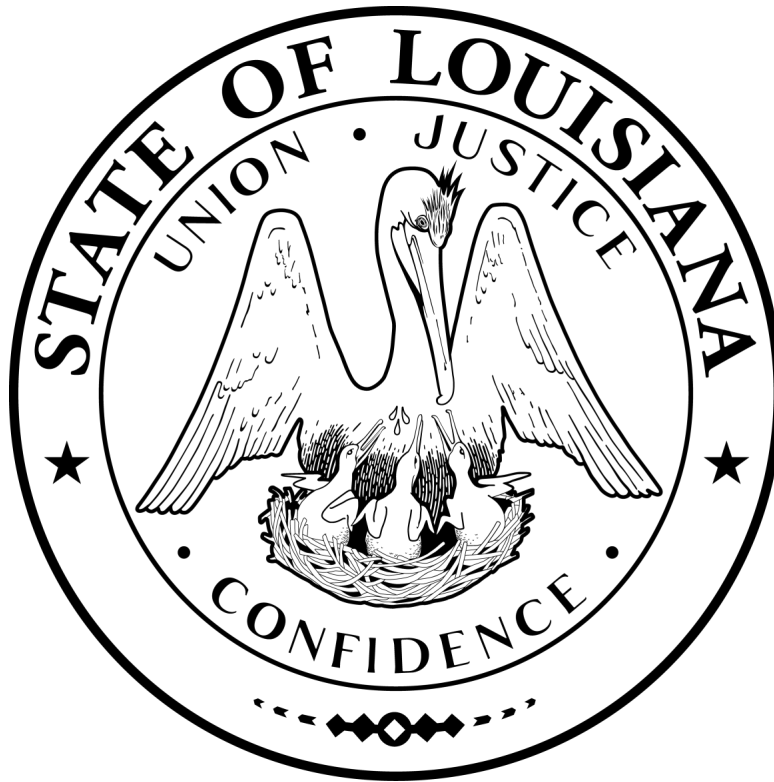


**OFFICE OF
STATE INSPECTOR GENERAL**

Stephen B. Street, Jr., Inspector General



**Department of Children and Family Services (DCFS)
Mitchell Robinson III**

March 18, 2024

OIG CASE NUMBER: 22-0010-I

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JEFF LANDRY
GOVERNOR



STEPHEN B. STREET, JR.
STATE INSPECTOR GENERAL

State of Louisiana
Office of the Governor
Office of State Inspector General

March 18, 2024

Honorable Jeff Landry
Governor of the State of Louisiana
PO. Box 94994
Baton Rouge, LA 70804-9004

Re: OIG Case Number 22-0010-I

Dear Governor Landry:

The attached report details our investigation into the fentanyl overdose death of two year-old Mitchell Robinson, III on June 26, 2022, and actions of the Louisiana Department of Children and Family Services (DCFS) related to the same.

We provided a draft copy of this report to DCFS, and its written response is included in the final report as Appendix A.

Respectfully Submitted,

A handwritten signature in blue ink, reading "Stephen B. Street, Jr., C.I.G.".

Stephen B. Street, Jr., C.I.G.
Louisiana State Inspector General

SBS/ss
Attachment



State of Louisiana
Office of the Governor
Office of State Inspector General

Case Number: 22-0010-I

Report Date: March 18, 2024

INVESTIGATIVE REPORT

The Office of State Inspector General (OIG) began an investigation after two year-old Mitchell Robinson III died of a fentanyl overdose on June 26, 2022.

In the weeks preceding the child's death the Department of Children and Family Services (DCFS) Centralized Intake telephone hotline received two calls - on April 12, 2022 and June 4, 2022 - from mandated reporters at Our Lady of the Lake North Emergency Room (OLOL North ER) in Baton Rouge after the child was brought in unresponsive on those dates. On each occasion the child was administered Narcan¹, an opioid reversal medication, to which he responded. Both times the child was transferred to Our Lady of the Lake Children's Hospital for further evaluation and admission. The two calls to the hotline were made by a registered nurse at OLOL North ER, where the child had been treated. Due to a variety of factors detailed further herein, neither report was accepted for investigation by DCFS, as it was determined upon initial review by a DCFS Intake Supervisor that the reports did not meet their criteria to initiate an investigation.

On June 6, 2022, a doctor and a social worker at Children's Hospital contacted a DCFS Prevention Team Supervisor at the Baton Rouge regional office, because the child was about to be discharged from the hospital. The supervisor, recognizing the significance of the child's response to Narcan, requested further review by a Centralized Intake Manager, who determined that the June 4 report did in fact meet the criteria to be accepted for investigation. The reasons for this determination are reflected in the email exchange reproduced below:

¹ Narcan is a brand name for Naloxone, a medicine that rapidly reverses an opioid overdose. Naloxone has no effect on someone who does not have opioids in their system. *Center for Disease Control and Prevention*

From: [REDACTED] <[REDACTED]@DCFS.LA.GOV>
Sent: Monday, June 6, 2022 12:05 PM
To: DCFS.Centralized Intake Inquiries <[REDACTED]@DCFS.CentralizedIntakeInquiries@LA.GOV>
Cc: [REDACTED] <[REDACTED]@DCFS@LA.GOV>; [REDACTED] <[REDACTED]@DCFS@LA.GOV>
Subject: Disposition review for Intake 1349005

Good Afternoon,

We received a call from the hospital with concerns of neglect of the alleged victim. In reviewing this intake, the child ingested a narcotic the hospital does not test for. Although his labs were negative; the child's condition was responsive to narcotic reversal (NARCAN). It was also mentioned in the report this is not the first incident. A previous intake was called in 4/12 with similar concerns. Please review this intake and reconsider a disposition change.

[REDACTED]
Prevention Team Supervisor

From: DCFS.Centralized Intake Inquiries
Sent: Monday, June 6, 2022 12:42 PM
To: [REDACTED] <[REDACTED]@DCFS@LA.GOV>; DCFS.Centralized Intake Inquiries <[REDACTED]@DCFS.CentralizedIntakeInquiries@LA.GOV>
Cc: [REDACTED] <[REDACTED]@DCFS@LA.GOV>; [REDACTED] <[REDACTED]@DCFS@LA.GOV>
Subject: RE: Disposition review for Intake 1349005

Good afternoon and thank you for the inquiry. After reviewing this report, it appears the information meets criteria for acceptance due to concerns of Lack of Adequate Supervision. The child, age 2, is suspected to have been exposed to narcotic substances for the second time since April 2022. Although there is not a positive drug screen, the substance that the child ingested may not show up on the specific test provided by the hospital. There are serious concerns regarding the safety of this child. Therefore, we are having this report re-entered with a disposition of Accepted for Investigation. Once the new intake is entered, we will OIE the initial report with incorrect disposition.

Thank you,

[REDACTED] LMSW
*Department of Children & Family Services
Centralized Intake, Child Welfare Manager 1*

The case was assigned as Priority 2 (P2), requiring the assigned caseworker to make face-to-face contact with a parent and the child within 48 hours per DCFS policy. On June 7, 2022 the case was assigned to a caseworker.

On June 17, 2022, nine days before Mitchell Robinson III's death, a third call was made to the DCFS hotline by a pediatric emergency physician who had seen the child at Children's Hospital after he was transferred from OLOL North ER on June 4. The physician made the call after receiving lab confirmation that the child had fentanyl in his system at the time of his June 4 admission, and she wished to determine whether any action had been taken by DCFS to ensure the safety of the child. The DCFS call-taker told the physician that he could take another report.

OIG's investigation showed that the caseworker assigned to the case also was assigned several other high priority cases during the same critical period of time. She also became ill shortly after she was assigned the Mitchell Robinson case. No in-person contact was made with a parent or the child by any DCFS employee before his death.

BACKGROUND

The Office of State Inspector General (OIG) is authorized to examine and investigate the management and affairs of all departments, offices, agencies, boards, commissions, task forces, authorities and divisions of the executive branch of state government ("covered agencies") concerning waste, inefficiencies, mismanagement, misconduct, abuse, fraud, and corruption, and to conduct all necessary investigations into the same. [La. R.S. 49:220.21; La. R.S. 49:220.24B] The Department of Children and Family Services is a covered agency.

DCFS is the state agency responsible for investigating allegations of child abuse or neglect by a parent or caretaker. DCFS Child Welfare policy 4-105 states that "the purpose of the investigation is to determine whether abuse or neglect has occurred." The DCFS website (dcfs.louisiana.gov) states: "If you suspect a child is being harmed, reporting your suspicions may protect the child and get help for the family."

DCFS operates a toll-free, statewide telephone hotline within its Child Welfare Division to receive and process reports of child abuse or neglect. Centralized Intake employees work several overlapping shifts to provide coverage 24 hours a day. Call takers make an initial assessment determining whether the report should be accepted for investigation. All calls are reviewed by a supervisor who makes the final determination as to the intake status. When a report is accepted, one of four response priorities is assigned based on a risk assessment that determines when a caseworker must make face-to-face contact with the child and a parent. The report is then routed to the regional office in the area of the state from which the call was made. The response priorities are:

- Priority 1 (P1) requires contact within 24 hours
- Priority 2 (P2) requires contact within 48 hours
- Priority 3 (P3) requires contact within three calendar days
- Priority 4 (P4) requires contact within five calendar days

The Louisiana Children’s Code defines “mandatory reporter” to include health practitioners, law enforcement officials, teachers and others as defined therein and requires a mandated reporter “who has cause to believe that a child’s physical or mental health or welfare is endangered as a result of abuse or neglect” to report to DCFS. [La. Ch. C. art. 603, 609] All initial reports made orally by a mandated reporter must be followed by a written report to DCFS within five days via the online Mandated Reporter Portal or by mail to Centralized Intake. [La. Ch. C. art. 610D]

The three calls to the DCFS hotline concerning Mitchell Robinson III can be summarized as follows:

On April 12, 2022 an OLOL North ER nurse called the DCFS hotline at approximately 2:13 a.m. to report that the parents of the child had brought him in “unresponsive.” The child’s mother said that he had been eating candy from an Easter egg hunt earlier in the day. The nurse said he was “apneic – no breathing at all.” She said that he had responded “to a couple rounds of Narcan, four rounds actually.” She added that “he responded to every dose that we gave him” and was “going on a Narcan drip” at Children’s Hospital. She also stated that “his drug screen was negative.” The nurse told the call-taker that the child’s mother said that he did not have any medical history and took no medicine. Law enforcement was not contacted by OLOL North ER. The nurse submitted the follow-up written report through the online portal in which she noted a “possible drug overdose.”

On June 4, 2022 the same OLOL North ER nurse called the hotline at approximately 5:28 a.m. and reported that when the mother brought the child in at about 1:15 a.m., he “was unresponsive, agonal² breathing.” At least four times during the call, the nurse stated that the child would “only respond to narcotic reversal medication.” She noted that the child responded to his first dose of Narcan, but did not respond well to the second or third doses. When asked about the child’s diagnosis, she replied that

² Agonal respiration is an abnormal breathing pattern characterized by labored breaths and gasping. *National Institute for Health*

his “diagnosis when he left here was respiratory distress.” The child was transferred to Children’s Hospital “for further evaluation and higher level care.” She added that “his lab work was negative for drugs . . . his drug screen was negative, the one that we run here.” The nurse informed the call-taker that “this is not the mother’s first time bringing this child in for this” but when asked if she could “pull up the chart and give me a synopsis about the last time,” she replied that she could not. Law enforcement was not contacted by OLOL North ER. DCFS has no record of a follow-up written report being submitted as required by La. Ch. C. art. 610D.

On June 17, 2022, ten days after the case was assigned to a DCFS caseworker, the pediatric emergency physician at Children’s Hospital called the hotline about Mitchell Robinson III, whom she had seen at Children’s Hospital on June 4. She informed the call-taker that the child had “overdosed in his own house twice” and “went home with parents who nearly killed him twice” after being admitted and treated at Children’s Hospital. Stating that she “would like to get this kid somewhere safe,” she informed the call-taker that she ordered extra blood work to test for fentanyl and had received confirmation that the child had fentanyl in his system at the time of his June 4 hospital admission. The hospital’s discharge summary after that admission said that the case was not accepted by DCFS. The physician informed the call-taker that “the only thing that Narcan works for is opiates.” She also referred to a news report of a “drug bust” at the residence of the child’s parents in May 2022.

The additional information provided by the pediatric emergency physician, including the child’s positive fentanyl test, was documented in an Intake Summary Form, referred to as a CPI-1, which was emailed later that day to the assigned case worker and her supervisor, as shown below:

From: [REDACTED]
Sent: Friday, June 17, 2022 11:09 AM
To: [REDACTED] DCFS@LA.GOV>; [REDACTED] DCFS@LA.GOV>
Cc: [REDACTED] DCFS@LA.GOV>
Subject: Case Assignment W. A [REDACTED]

Good morning,

Please find attached a CPI-1 with an additional to a case already assigned to you.

Thanks,

[REDACTED] RSW, CWS IV
Department of Children and Family Service Supervisor
160 South Ardenwood Dr.
Baton Rouge, LA. 70806
(225) [REDACTED] (Office)
(225) [REDACTED] (Work Cell)

Court records show that on May 11, 2022, East Baton Rouge Parish Sheriff's Office detectives executed a search warrant at 5962 Denova Street, the residence of the parents of Mitchell Robinson III. Items seized included marijuana, methamphetamine and fentanyl. The child's parents, Mitchell Robinson, Jr. and Whitney Ard, were arrested and booked on numerous felony drug charges, including Illegal Use of Controlled Dangerous Substances in the Presence of a Child under Seventeen, a violation of La. R.S. 14:91.13. DCFS has no record that a call was received from law enforcement. The Affidavit of Probable Cause filed in court records does not state what action was taken regarding the arrestees' two young children.

In an initial meeting with DCFS Secretary Marketa Walters, Assistant Secretary of Child Welfare Rhenda Hodnett and others, OIG investigators were given a verbal timeline of DCFS' involvement with Mitchell Robinson III. DCFS administrators believed that the information provided in the hotline calls by the OLOL North ER nurse was not clear, as the caller stated on each occasion that the hospital's "drug screen was negative." Those who determined that the reports would not be accepted for investigation apparently understood the negative drug screen to show that the child had no illegal drugs in his system and that there must be some medical explanation for his condition. It was acknowledged that Centralized Intake employees had received no training regarding the medical use of Narcan.

The Centralized Intake Supervisor stated that she confirmed the "not accepted" determination and advised OIG investigators that the lack of illegal drugs in the child's drug screen was given much weight in her decision. She said that when she

followed up with medical staff at OLOL North ER regarding the June 4 report, the possibility of a seizure disorder was discussed. This led her to believe a medical issue existed, rather than abuse or neglect. The Intake Supervisor stated that she was unable to speak with the OLOL North ER registered nurse who made the report, as she had completed her shift. However, her intake notes indicate that she was able to talk with someone who provided chart notes. She stated that she had received no training about the medical use of Narcan at that time.

The Centralized Intake Manager informed OIG investigators that she had personal knowledge of why Narcan is used, but had received no training on the use of the drug or the significance of a child's positive response to it.

Once the report was accepted for investigation, the case was assigned to a Child Welfare Specialist, who provided investigators with a timeline of events beginning with the assignment of the case.

The caseworker stated that she was assigned this case on the afternoon of Tuesday, June 7, while in the middle of a Priority 2 sex abuse investigation. She said that she was off from work on previously approved leave the following day and upon returning to work, was instructed by her supervisor to remain in the office on Thursday, June 9, and Friday, June 10, to work on backlogged cases.

The caseworker further stated that Mitchell Robinson III's case, a Priority 2 requiring a response within 48 hours, was already "out of the response window" when it was assigned to her because it was initially not accepted. She began working on the case on Tuesday, June 14, and left a "call me letter" at an apartment on Greenwell Springs Road, the address provided for the child's mother by the OLOL North ER nurse in the hotline calls. She documented the same by taking a photo. She received a phone call from a person identifying herself as Whitney Ard on the same date and set up a meeting to speak with her on Thursday, June 16.

The caseworker told OIG investigators that she was called out on another case on the night of June 14 and worked until 3 a.m. She was back at her office on Wednesday, June 15, at 8 a.m. and worked all day taking custody of a child. That night, she was again called out and worked all night into her regular work hours on Thursday, June 16. This call-out also required children to be taken into DCFS custody. She stated that she was instructed to go home after she completed the necessary paperwork regarding the children taken into custody. The meeting with the mother, Whitney Ard, scheduled for June 16 did not occur. State offices were

closed for the Juneteenth holiday on Friday, June 17. Nevertheless, she said she was called out three times on that day.

On Saturday, June 18, the caseworker was contacted by her supervisor and directed to respond to another call out. She informed her supervisor that she was ill, but she responded and worked all that day. On Sunday, June 19, she was again called out on a Priority 1 sex abuse case and worked the entire day. On Monday, June 20, the caseworker contacted her doctor and went on sick leave. She was on sick leave from June 20 through June 24 and returned to work on Monday, June 27, the day after Mitchell Robinson III died.

OIG investigators spoke with the supervisor by phone and made several attempts to schedule an interview with her. She was no longer employed by DCFS at the time, having resigned in August 2022. DCFS administrators had removed her supervisory responsibilities immediately after Mitchell Robinson III's death, after which she went on medical leave until her resignation. She did not make herself available for an interview.

In December 2022 Terri Porche Ricks was appointed as DCFS Secretary by the governor after the resignation of Marketa Walters. Ricks had previously served the agency as Deputy Secretary since 2016 and as Undersecretary from 2004 to 2008.

In September 2023 Dr. Rebecca Hook, a pediatric emergency physician, was appointed as DCFS' first Director of Medical Services in the agency's Child Welfare Division. According to a DCFS press release, "in addition to serving as an in-house clinical resource for caseworkers and other staff responding to cases of child abuse and neglect, Dr. Hook will create medical standards and healthcare guidelines for children and youth involved in child welfare."

The office of state Child Ombudsman, to be appointed by the Legislative Auditor, was created by Act 325 of the 2023 Regular Session enacting La. R.S. 24:525. The Child Ombudsman is to act as an independent ombudsman monitoring and evaluating the public and private agencies involved in the protection of children and delivery of services to children, reviewing state policies and procedures to ensure they protect children's rights and promote their best interest, and safeguarding the welfare of children through educational advocacy, system reform, public awareness and training. [La. R.S. 24:525B]

In October 2023 Kathleen Stewart Richey, retired East Baton Rouge Parish Juvenile Court Judge, was appointed by Legislative Auditor Mike Waguespack as Louisiana's first state Child Ombudsman.

OIG investigators met with both Dr. Hook and Judge Richey to discuss issues within the Child Welfare Division of DCFS.

On September 29, 2022 an East Baton Rouge Parish grand jury indicted Whitney Ard on a charge of Second Degree Murder. The case is case pending in 19th Judicial District Court (*State of Louisiana v. Whitney Ard*, #DC-22-04779, Section VII).

The East Baton Rouge Parish District Attorney's Office filed bills of information charging Whitney Ard and Mitchell Robinson, Jr. with numerous felony drug charges and weapons charges. The cases are pending in 19th Judicial District Court (*State of Louisiana v. Whitney Ard*, #DC-22-03753, Section V; *State of Louisiana v. Mitchell Robinson, Jr.*, #DC-22-03764, Section V).

A federal grand jury returned a three-count indictment charging Mitchell Robinson, Jr. with Possession with Intent to Distribute Controlled Substances (methamphetamine, fentanyl, heroin and tramadol), Possession of a Firearm in Furtherance of a Drug Trafficking Crime, and Possession of a Firearm by a Convicted Felon. On October 18, 2023 Robinson entered a guilty plea to the charges before U.S. District Judge Shelly Dick. Sentencing is scheduled for April 11, 2024. (*United States v. Mitchell Robinson, Jr.*, #23-34, Middle District of Louisiana).

CONCLUSIONS

Among the factors that contributed to the death of Mitchell Robinson III, were the following:

- Multiple failures by DCFS Child Welfare management, especially the caseworker's immediate supervisor, to wit:
 - allowing the caseworker to be overburdened with assigned cases requiring prompt contact;
 - failing to assist with that caseload;
 - failing to check on whether initial in-person contacts were made in newly-assigned cases; and
 - failing to manage the caseworker's assigned cases while she was out on sick leave for an entire week.
- DCFS intake personnel had not been trained on the medical use of Narcan, a drug used exclusively for opioid reversal, and thus did not initially recognize the significance of the child having been revived on two occasions with the drug;
- Law enforcement was not contacted by medical personnel on those two occasions;
- Toxicology screens used by the hospital did not test for synthetic opioids, leading to initial "negative" results that caused confusion among DCFS personnel not familiar with the medical use of Narcan;
- DCFS has no record of being contacted by law enforcement following the drug arrests of the child's parents in May 2022;
- Poor and vague communication between medical personnel and DCFS on the first two hotline calls;

Notwithstanding all of the above, there is no factor more significant than the critical nine-day period between June 17, 2022 and June 26, 2022, during which DCFS personnel, including the assigned case worker and supervisor, had specific knowledge that Mitchell Robinson III had tested positive for fentanyl at the time of his June 4 hospital admission. During those nine days, DCFS personnel took no action whatsoever to ensure the safety of the child.

APPENDIX A



Executive Division
627 North 4th Street
Baton Rouge, LA 70802

(O) 225.342.9538
(F) 225.342.8636
www.dcfsl.a.gov

Jeff Landry, Governor
David N. Matlock, Secretary

March 1, 2024

The Honorable Stephen B. Street, Jr.
Inspector General
Office of State Inspector General
P.O. Box 94095
Baton Rouge, LA 70804-9095

Dear Mr. Street:

The Department of Children and Family Services (DCFS) has reviewed your report on OIG Case Number 22-0010-I, which reviews the agency's handling of the Mitchell Robinson III case in 2022. I became the Secretary of DCFS in January 2024, as part of the new administration. While this matter occurred under the prior administration, I thank you for the opportunity to respond.

The death of Mitchell Robinson due to a fentanyl overdose is truly a tragedy. It is important to note that Mitchell died in June 2022, before the impact of fentanyl exposure to young children was widely known. At the time, it also was not widely known that a person would only respond to Narcan if an opioid were present and that negative drug screens do not necessarily point to the absence of drugs in the system. Even today, typical general drug screens in emergency rooms do not test for fentanyl. As a result of this case and proliferation of fentanyl in our communities, the Child Welfare Division has directed staff to specifically request a test for fentanyl from a medical provider anytime Narcan is used to revive a child. We also instituted a policy change that requires all reports of child abuse or neglect regarding children age 3 and under, which come from medical providers, to be accepted for investigation unless overridden by a manager. Our team developed an expansive set of strategies to stabilize and increase the capacity of our workforce. We streamlined the assignment of cases in the field offices to have greater visibility on the number of new assignments made to individual workers and to provide for reassignment of cases as needed and based on available resources.

This report illustrates the overwhelming workload and schedule that our staff are juggling. In State Fiscal Year 2023, there were 25,862 Child Welfare investigations received, a 43.4% increase over the 18,032 investigations received in SFY2022. We have also seen an increase in urgency, with 75% of cases now requiring face to face contact within 48 hours. Though we have focused on hiring and retaining staff, we still do not have an adequate number of caseworkers to keep pace with the increase in investigations over the last several years. All of this impacts services and our ability to meet the needs of Louisiana's children and families.

While we continuously work to improve services to our clients, we simply cannot do this critical work alone. The tragic death of Mitchell Robinson is a stark reminder that everyone is responsible for the safety and well-being of our children. Parents and family members must protect children from abuse and neglect; those who use substances, whether illegal or not, must keep them out of the reach of children; community members must rally together to address the needs of families; law enforcement, medical professionals, education professionals and others must report suspected child abuse and neglect in a consistent and thorough manner. Together, we can create a safety net to help struggling families and prevent harm from coming to children.

Sincerely,

David N. Matlock
Secretary

