OKLAHOMA COMMISSION ON CHILDREN AND YOUTH

OFFICE OF JUVENILE SYSTEMS OVERSIGHT

Report Release Date: October 21, 2016

Review of the Near-Death of B.C.

Mayes County, Oklahoma

General Information

The Office of Juvenile Systems Oversight (OJSO) received a request for a public report regarding the near death of B.C. A felony count of Child Neglect by Munchausen by Proxy was filed in Tulsa County District Court on September 26, 2016, against the child's mother, Caitlin Lewis, and bond was set at $50,000.

Authorization

The following is a summary of the actions taken by the Oklahoma Department of Human Services (OKDHS); the dates and outcome of investigations and actions by the OKDHS; the actions taken by the district attorney; the dates and summary of judicial proceedings; and the rulings of the court, as authorized by 10A O.S. Section 1-6-105.

Identifiers

Child's name:	B.C.
Age at time of incident:	Three years old
Date of near death:	June 29, 2016
Sibling One:	Eleven years old
Sibling Two:	Ten years old
Step-Child One:	Nineteen years old
Step-Child Two:	Fifteen years old
Person Responsible for the Child (PRFC):	Caitlin Lewis

The Oklahoma Commission on Children and Youth (OCCY) did not become aware of this family until the near-death incident involving B.C.

Near Death Incident

On June 30, 2016, the OKDHS received a report that B.C. was admitted to a medical facility in Tulsa, Oklahoma, because of a reported seizure disorder. Reportedly, the day before the report the child was found wandering the halls of the hospital and Ms. Lewis requested hospital staff provide the child a medication to induce sleep. The request was reportedly denied by the medical staff. Later that evening, a nurse at the facility

went to the child's room and saw a substance around the child's mouth. Upon inquiry, Ms. Lewis reported the child was vomiting, but medical personnel could not find evidence of vomit. However, the nurse found a cup with a pill in it within reach of the child. The nurse reportedly bagged the cup and pill for testing purposes; Ms. Lewis' response to the nurse was that the pill belonged to Ms. Lewis and that she had mixed her medication in the cup. A while later, the child became unresponsive and was placed on a ventilator. The child did not have any signs of seizure activity while at the medical facility.

The OKDHS accepted this as a Priority I Investigation. The family was working with an OKDHS Family Centered Services (FCS) worker at the time of this incident. The FCS worker documented that Ms. Lewis contacted her by text that the child was brought to the facility on June 28, 2016, because of a seizure and also documented that Ms. Lewis reported the near-death incident the following day. The FCS worker documented contact with the mother and child on June 30, 2016. The worker documented that upon arrival, nurses were checking on the child and Ms. Lewis came out of the bathroom of the hospital room. She stumbled, ran into a wall and had slurred speech.

The Child Protective Services (CPS) worker documented contact with the child and mother at the facility on June 30, 2016. She reportedly told the CPS worker that she was at an inpatient facility the previous weekend and was prescribed several medications upon her release. One of the medications was the substance Ms. Lewis claimed was in the cup found in the child's hospital room. Ms. Lewis reportedly told the CPS worker that her gait was unsteady because she was not wearing her glasses and her speech was slurred because she had false teeth. Ms. Lewis also reportedly said the reason that medical personnel could not detect seizure activity was because the child's seizures were "cluster seizures" that could not be detected by an electroencephalogram (EEG). When questioned further by the CPS worker, Ms. Lewis reportedly admitted to administering one-half of Ms. Lewis' medication to the child because she felt the hospital staff was not helping her child's seizure disorder. The CPS worker documented she told Ms. Lewis to leave the medical facility immediately and not to return without a CPS representative present. The worker documented that the child's father responded to the hospital and requested custody of the child.

The OKDHS documented that the child stabilized quickly and was released two days later to the biological father. Further documentation indicated that the child was seen by a physician with expertise in child abuse and neglect on July 28, 2016, and the child was doing extremely well and taking no medication. The OKDHS Substantiated the allegations of Neglect-Near Death and Abuse-Fabricated or Induced Illness (Munchausen Syndrome by Proxy). The OKDHS recommended that the biological father obtain full custody of the child and that Ms. Lewis receive a mental health assessment.

Prior Involvement of the PRFC with the Oklahoma Department of Human Services

Caitlin Lewis was previously involved with the OKDHS and three of the reports were pertinent to this report.

The first pertinent report was received by the OKDHS on December 12, 2005, and alleged Threat of Harm by Ms. Lewis as to Sibling One. Reportedly, Ms. Lewis suffered from a mental health condition but was not diagnosed by a medical or mental health professional. She had reportedly left Sibling One in the care of relatives after leaving with the child for several days. The relatives were reportedly going to obtain custody of the child. The OKDHS Screened-Out this referral.

The second pertinent report was received by the OKDHS on October 3, 2007. The report alleged that a relative was caring for Sibling Two and noticed a yellow discharge around the child's nose. The reporter also alleged that Ms. Lewis was taking the child to different doctors to obtain prescriptions for several types of opioid medication. The OKDHS Screened-Out this referral.

The third pertinent report was received by the OKDHS on April 26, 2016. The report alleged that Ms. Lewis did not administer seizure medication to B.C. as prescribed. Reportedly, the child had a seizure on April 25, 2016, but tests performed at a medical facility indicated the child did not have the medication in her blood. Also reported was that the child had seizures at an emergency room but results from an EEG did not indicate any seizure activity. Ms. Lewis reportedly stated the reason for the blood test results was that the child's father was watching the child the previous weekend and did not administer the medication. The OKDHS accepted this as a Priority II Investigation. During the course of the investigation, the CPS worker documented that Ms. Lewis informed friends that B.C. had died. The CPS worker and supervisor found the child the same day in her mother's care at the home of her husband's parents. The OKDHS documented a Child Safety Meeting (CSM) with the family and allowed the child to remain in the home with the stepfather's parents. The child's father was permitted to exercise weekend visitation with the child. The OKDHS Substantiated the allegation of Threat of Harm as to Ms. Lewis and had opened a Family Centered Services case a few days before the near-death incident.

Judicial proceedings prior to the child's near death incident

The Oklahoma State Courts Network (OSCN) documented that a guardianship of Sibling One to a relative was granted in the Creek County District Court in 2005. The guardianship was appealed by Ms. Lewis to the Court of Civil Appeals on September 21, 2007. The guardianship was affirmed by the Court of Civil Appeals on September 17, 2008.

OSCN records documented that the biological father of Sibling Two received emergency custody of Sibling Two on December 28, 2007.

OSCN records documented that a paternity and custody petition was filed by the father of B.C. on September 16, 2016, in Tulsa County District Court.

It should be noted that Ms. Lewis was found deceased in her jail cell at the David L. Moss Criminal Justice Center on October 5, 2016.