

**OKLAHOMA COMMISSION ON CHILDREN AND YOUTH  
OFFICE OF JUVENILE SYSTEM OVERSIGHT**

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Report Release Date: March 15, 2007

Review of near death of Kentrell Warren  
Of Muskogee and Wagoner Counties, Oklahoma

Dates and outcome of investigations and actions taken by the  
Department of Human Services  
Actions taken by the District Attorney  
Dates and summary of judicial proceedings and rulings of the Court

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On November 28, 2006, the Office of Juvenile System Oversight (OJSO) received a request for a public report on the near death of the child, Kentrell Warren. The near death incident occurred on November 12, 2006. The following is a summary of the actions taken by the Department of Human Services; the actions taken by the district attorney; judicial proceedings; and the rulings of the court as authorized by O.S. 10, Chapter 70, Section 7005-1.4, E (below).

**Authorization**

Title 10, Chapter 70, Section 7005-1.4, E, states:

E. 1. In cases involving the death or near death of a child when a person responsible for the child has been charged by information or indictment with committing a crime resulting in the child's death or near death, there shall be a presumption that the best interest of the public will be served by public disclosure of certain information concerning the circumstances of the investigation of the death or near death of the child and any other investigations concerning that child, or other children living in the same household.

2. At any time subsequent to seven (7) days of the date the person responsible for the child has been criminally charged, the Department of Human Services, the Oklahoma Commission on Children and Youth, or the district attorney may release the following information to the public:

a. a confirmation that a report has been made concerning the alleged victim or other children living in the same household and whether an investigation has begun,

b. confirmation as to whether previous reports have been made and the dates thereof, a summary of those previous reports, the dates

and outcome of any investigations or actions taken by the Department of Human Services in response to any report of child abuse or neglect, and any actions taken by the district attorney after submission of any investigative report, and

c. the dates of any judicial proceedings prior to the child's death or near death, a summary of each participant's recommendations made at the judicial proceedings, and the rulings of the court.

3. Any disclosure of information pursuant to this section shall not identify or provide an identifying description of any complainant or reporter of child abuse or neglect, and shall not identify the name of the child victim's siblings or other children living in the same household, the parent or other person responsible for the child or any other member of the household, other than the person criminally charged.

**Identifiers:**

Child's name: Kentrell Warren  
Age at time of incident: Six months old

Mother: Angela Warren  
Aunt: Latonya Whitelaw (Angela Warren's biological sister)

Siblings: Sibling 1 Age: Five years old  
Sibling 2 Age: Four years old  
Sibling 3 Age: Two years old  
Sibling 4 Age: One and one half years old  
Sibling 5 Age: Six months old

**Summary of actions taken by the Department of Human Services; actions taken by the district attorney; judicial proceedings; and the rulings of the court:**

**February 23, 2003**

First DHS Referral

Summary of Allegations: According to the Referral Information Report, incident description, [sibling 2], a one-year-old male, was being treated for a respiratory virus at Muskogee Regional Hospital. On the evening of February 23, 2003, the child was found by a nurse "laid out flat on his back with his eyes rolled back in his head." Reportedly, the doctor stated "that this could be an indication that someone may have tried to smother the child." The caller

stated that the mother, Angela Warren, was not present when the child was allegedly smothered, but that the maternal aunt and maternal grandmother “were the family members in the room at the time.” The child recovered from the incident.

Findings: “Services Recommended.” According to the DHS Report to District Attorney, Summary / Recommendation:

[The] worker is finding the allegations unconfirmed but services recommended. Mrs. Warren does not believe her sister would do anything to cause harm to either [sibling 2] or [sibling 1]. Worker observed the medical records and found that during the time of incident, Mrs. Warren’s sister was with the child, however the progress notes were documented as late entries. . . [The child welfare] worker made a written agreement for Mrs. Warren not to leave her children alone with her sister. . . Worker is not requesting a petition at this time.

#### DHS Safety Plan

On February 23, 2003, the mother, Angela Warren, signed a safety plan prepared by a DHS child welfare worker. The safety plan stated:

Ms. Warren will personally care for her children and will not allow her sister (Tonya Warren) to have access to these children . . . until the investigation is completed. If Ms. Warren fails to cooperate or [fails to follow] through with the safety plan as agreed, the D.A.’s office will be notified and the children may be placed in state’s custody. At this current time [sibling 1] is in the home with his paternal grandmother. . .

#### **June 13, 2003**

#### Second DHS Referral

Summary of Allegations: Reportedly, Angela Warren was negligent by leaving her child with a “mentally limited aunt who was not capable of caring for her children.” The Referral Information Report stated:

The reporting party was very upset. She said . . . [sibling 2] is dead at MRMC [Muskogee Regional Medical Center]. She reported she does not know what happened to him. She said awhile back child welfare in Muskogee County investigated the mother and the mother was told not to have the child around her sister because the sister was slow. . . The mother brings her child to her mother’s house in Muskogee to be cared for while the mother works. The mother got a call to come to the grandmother’s home because something was wrong with her baby. The mother came and took the child to the hospital and now the baby is dead. . . The supervisor visited with Lance Whittman, MPD

[Muskogee Police Department], at the hospital. . . He [Lance Whittman] said the child was in the care of an aunt, Latonya Warren at the time.

Findings: “Confirm – Court Intervention Requested.” The Report to District Attorney, Summary / Recommendation, stated:

The maternal aunt who is mentally limited was babysitting the children at the time of the youngest child’s death. She was unable to relate the information leading up to his death in a consistent and credible manner. . . . The mother has a history of leaving the children with the aunt and was advised in February there were some concerns with the aunt’s ability to provide adequate care. The mother continued to leave the children with the maternal aunt; she also left the children with the paternal aunt on a regular basis. . . . It was established during the investigation that the children were rarely in the care of their mother. The mother had originally allowed the oldest child, [sibling 1], to be in the care of his father and paternal aunt during the completion of the investigation. The mother then decided she did not feel the child was safe with the father or paternal aunt. The child was placed in the custody of the Department of Human Services on 8/25/03.

The DHS requested the District Attorney to file a deprived petition for [sibling 1], Angela Warren’s two-year-old son. [Sibling 1] was placed in custody on August 25, 2003, and remained in DHS custody until his adoption on October 19, 2006.

#### DHS Paper File: Muskogee Police Department Offense Report

The DHS paper file included a Muskogee Police Department offense report, dated 6/13/03. The report included interview information regarding the death of [sibling 2]. The following was excerpted from the report describing an interview with the child’s attending physician:

[Child welfare worker] and I then went to the Children’s Clinic to speak to [child’s attending physician] and to see if he had located the medical records for [sibling 2]. [The child’s physician] had located the records and confirmed that [sibling2] was the child that had the unknown hypoxic episode at MRMC [regarding a previous hospitalization for respiratory concerns]. He added that [sibling 2] intravenous tube had been backed up and although it was normal the aunt had complained about it to a nurse. When checked again the IV tube had been rerouted and plugged into a different port. We asked [the physician] what he thought about the hypoxic episode and he showed me a card that he had placed into the medical records that had “attempted murder” written on it. He explained that [sibling 2] was doing fine and was actually being discharged when it happened and a blood gas test was done and it showed the boy’s acid level to be high. [Sibling 2] had a cat scan and it showed everything to be

normal. There was no medical reason found for him to have had a hypoxic episode.

### **June 14, 2003**

#### Report of Investigation by Medical Examiner

The DHS paper file included the medical examiner's investigation report regarding the death of [sibling 2]. The Final Summary was included below in entirety:

This 17-month-old black male child died shortly after arrival at the emergency department of Muskogee Regional Medical Center. He was brought there after reportedly becoming suddenly unresponsive while in the care of a baby sitter. The precise circumstances of what happened immediately before this unresponsiveness are unclear. He was otherwise thought to be healthy. He had been hospitalized in February of 2003 for asthma and respiratory syncytial virus infection. During that hospital stay, just prior to discharge and at a time when his condition was considered to be good, he had an apparent brief episode of hypoxia and acidosis which was unexplained. The sitter was reportedly present when this incident happened.

At autopsy an anatomic cause of death is not identified. Toxicology screening is non-contributory. The cause of death is undetermined. In view of the history and the circumstances surrounding the death, it must be viewed with suspicion. The manner of death is considered unknown.

### **August 22, 2003**

#### DHS Timeline: Warren Investigation

DHS child welfare created a summary entitled: "Timeline: Warren Investigation," regarding [sibling 1] and a voluntary placement of [sibling 1] by the mother with the paternal aunt. The timeline is included in entirety:

1. Referral: Friday, June 14, 2003, [police officer] request Child Welfare at MRMC ER due to death of 17-month-old black male, [sibling 2]. Child was being cared for by 17-year-old, Latonya Warren, sister of the mother, who is reported to be slow and mentally limited.
2. Mother, Angela Warren gone from ER and has sent child to be with father, [name withheld] and his family in Tulsa.
3. Unable to locate mom for an interview until Wednesday June 19, 2003. Mom into Police Department continues to say child with father and his family. Mom wants to continue to leave child with dad and family.

4. Biggest concern for Child Welfare and law enforcement is that mom will get child and leave with her sister, Latonya Warren, who was caring for [sibling 2] when he died.
5. Information from [the child's physician] regarding concerns with the aunt in February when she was with the child in the hospital. The aunt is not supposed to be baby sitting the child due to concerns and her mental limitations. Investigation establishes the mom always left the children with her sister or with the dad and his family.
6. Mom voluntarily places the oldest child, [sibling 1], with paternal aunt, [name withheld]. Continued concerns of investigation with how child died and his 17-year-old aunt was babysitting. She took 25 to 30 minutes to call a friend for help, the friend then called EMS.
7. Mom is permitted to visit with the child she has 4<sup>th</sup> of July weekend and is welcome to come by aunt's house to visit. Mom can be with child at aunt's and go to doctor appointments, etc. Mom visits sporadically, has telephone contact with worker and aunt sporadically, no set schedule or routine as the department does not have custody or control over visits. Only criteria is that the mom does not leave [sibling 1] with her sister, Latonya Warren.
8. Wednesday, August 13, 2003, grandma leaves voice mail regarding need for medical card. Searching for medical number on [sibling 1], system shows mom receiving services in Wagoner county. Mom receiving food stamps, medical, and disability. Contact Wagoner county worker who advises mom received \$3552.00 first part of July for back payment of social security. Worker advises child is not living in home with mom, but living with paternal aunt.
9. Tuesday, August 19, 2003, aunt calls because [sibling 1] needed to go to the doctor. Mom makes appointment with [the child's physician] to accompany aunt, she is suppose to provide medical card after numerous request. Worker looks for number, mom does not show up for doctor appointment at Children's Clinic. Mom suppose to see child this date when going to the doctor 08/20/03.
10. Report made to OIG (Office of Investigator General) for fraud as mom lies to Wagoner county worker claiming [sibling 1] lives with her and she is receiving food stamps and disability on him.
11. Mom calls worker on Wednesday August 20, 2003, wanting to know if ME report is back, worker says investigation is ongoing and still waiting for ME report. Mom says she want to take [sibling 1]. Worker confronts her about food stamps, medical, disability, and social security on [sibling 1]. Mom had denied in past the she applies for social security, worker advised her the [paternal] aunt needed the services as she has the child in her home and has not yet received any services for him.
12. Friday, August 22, 2003, worker e-mails ADA, Sejin Brooks, regarding information on fraud and report to OIG, advised ME report still not available. ADA says will have deprived case only as there is a no-file

on the criminal case. May be able to do voluntary agreement due to mom voluntarily placing child with his aunt.

### **August 25, 2003**

#### Affidavit requesting Temporary Emergency Custody Order

DHS child welfare submitted an affidavit to the district court of Muskogee County, dated August 25, 2003, requesting a Temporary Emergency Custody Order for [sibling 1]. The affidavit documented the following reasons for custody:

A referral was received on 6/13/03 regarding the death of [sibling 2] while he was being babysat by his mentally limited maternal aunt. The mother of the child, Angela Warren, continued to leave the children, [sibling 2] and [sibling 1] with the aunt after being told by DHS she was not mentally capable of caring for children. During the investigation on the child death of [sibling 2], the mother voluntarily placed the oldest child, [sibling 1] with the paternal aunt, [name with-held]. The mother had agreed to leave the child with the aunt during the investigation. The mother does not have a job or housing and continues to move back and forth between Muskogee and Wagoner. The mother has the child back living with her at this time and the Department of Human Services feels the child is not safe in the mother's care. Therefore, the Department of Human Services is requesting a Temporary Emergency Custody Order.

#### Order Placing Temporary Emergency Custody

On August 25, 2003, temporary custody of [sibling 1] was placed with the Department of Human Services by the district court of Muskogee County.

### **April 12, 2004**

#### Third DHS Referral

Summary of Allegations: Reportedly, Angela Warren gave birth to a baby boy, [sibling 3], on April 11, 2004. The mother had an open permanency planning case, due to a previous child death. An older sibling is in the custody of DHS.

Findings: "Services Recommended." According to the Report to District Attorney, Summary / Recommendations:

The mother and father of the newborn agreed to a Voluntary Service Agreement. The mother currently has an open permanency planning case with a child in DHS custody, due to the death of another child. The child died in the care of [a] mentally retarded aunt who was babysitting. The

mother had previously been instructed by DHS not to allow the aunt to baby-sit. The mother stated she has met the requirements on her treatment [plan] and feels her child will be returned soon. She stated she has learned never to leave her children with an irresponsible [sp] caretaker. The mother and father agreed to a voluntary service agreement that basically states they will only leave the child with his paternal grandmother or a licensed daycare. Further services were declined. No court action is requested at this time.

#### **April 23, 2004**

Letter to the district court: completion of parenting classes

A counselor reported to the court that Angela Warren had successfully completed the parenting curriculum and services to address “the individual issues recommended on the Child Welfare treatment plan.” The counselor recommended “visitation be increased so she can have the opportunity to apply what she has learned on a daily basis.” The counselor continued: “As long as these visits provide a safe and stable environment for her children I recommend custody be placed with Angela in 30 days.”

#### **May 5, 2004**

Oklahoma Children’s Services (OCS) Referral for Service

DHS requested OCS to initiate Comprehensive Home Based Services (CHBS) on May 5, 2004 in the Warren household. The referral for service indicated that mother needs assistance with risk assessment, parenting, time management, educational goals and priorities.

#### **May 6, 2004**

DHS Individualized Service Plan (ISP) Progress Report

The Individualized Service Plan review documented that Angela Warren had completed parenting classes and drug treatment. The service plan required continued random drug tests and individual counseling.

#### **June 8, 2004**

Fourth DHS Referral

Summary of Allegations: Reportedly, Angela Warren left her baby in the car while she was in a liquor store. The reporter also indicated that Angela was “sloppy” drunk every weekend.

Findings: "Services Recommended." According to the Report to District Attorney, Summary / Recommendations:

An unannounced home visit was made. Sleeping arrangements were addressed and found appropriate. Protocol was modified because [father of sibling 3] failed to cooperate with CWS [child welfare services] and be interviewed. [Sibling 3] was clean and appropriate. There was food for [sibling 3]. [Sibling 1] is in custody of CWS and has been placed with his paternal aunt. Angela has completed her treatment plan and is working on an aftercare plan with TANF [Temporary Assistance for Needy Families.] OCS is currently working with Angela in her home and is there weekly. CWS Specialist sees her at least once every 28 days and Angela appears to be doing as she is requested to get [sibling 1] home. Angela denied leaving the baby in the car while she was at the liquor store. Angela said she was inside the grocery store next to the liquor store and the baby was inside with her. She has denied being drunk on weekends. At this time it appears [sibling 3] is safe with Angela. There are no further recommendations.

#### **June 25, 2004**

##### Child Welfare/Community Services Staffing

On June 25, 2004, the DHS child welfare worker met with the community services case manager to review the progress of Angela Warren. The report documented: "Angela is not cooperating with CCM [community case manager] on visits and will not make contact with CCM." The report also indicated Angela had lost her job and her car.

#### **August 13, 2004**

##### Child Welfare/Community Services Staffing

On August 13, 2004, the child welfare / community services staffing report documented: "Visits [mother and child visitation] stopped due to BF [boyfriend] in shooting. Transportation issues."

#### **December 9, 2004**

##### Fifth DHS Referral

Summary of Allegations: Reportedly, Angela Warren gave birth to a baby boy, [sibling 4], on December 9, 2004. The mother had an open permanency planning case in Wagoner County. [Sibling 4] was born at 25 weeks gestation and weighed one pound, 15 ounces. Reporter stated that mother had poor

pre-natal care. The father of the baby is a seventeen-year-old male presently incarcerated.

Findings: "Services Recommended." According to the Report to District Attorney, Summary / Recommendations:

The investigation has been completed. An unannounced home visit was made. Sleeping arrangements were addressed and found appropriate. Modification of protocol was made and approved when [sibling 1's] father, [name withheld] refused to talk to the Child Welfare Specialist. . . [Sibling 4] was born prematurely at 25-week gestation. [Sibling 4] is doing well and has gained weight. He now weighs over 3 pounds and is off all machines, although he is still in St. Francis ICU. There is past Child Welfare history on Ms. Warren and [father of sibling 4]. There was an infant death in the home in 2002, which resulted in the removal of [sibling 1]. There were allegation[s] that Ms. Warren left the infant with her mentally retarded sister who may have suffocated him. Charges were never filed and have been dismissed by Muskogee County D.A. Ms. Warren has completed her treatment plan and has recently been allowed over night visiting privileges with [sibling 1]. She is working toward reunification in her home. [The father of sibling 1] has not completed his treatment plan, but is attending counseling with [sibling 1]. Oklahoma Children's Service is currently involved with Ms. Warren and her children. She has moved to a nice apartment in a good neighborhood. Ms. Warren has recently been granted Social Security Supplement and is planning to return to work after the release of [sibling 4] from St. Francis Hospital. The collaterals have stated they feel the Warren children are being well cared for and there is no threat of harm in the home. The children's paternal grandmother, [name withheld], visits with the children often and has been a source of support for Ms. Warren. The Findings are Services Recommended as it is recommended OCS remain in the home. There are no other recommendations at this time.

Sibling 1 remained in DHS custody in a kinship foster home.

## **December 20, 2004**

### **Post Adjudication Review Board [PARB] Report to Court**

The PARB board reported recommendations and findings to the court. The board reported the mother had not made "marked progress to correct," and recommended the mother continue working on the treatment plan and maintain the child in long term foster care.

**February 14, 2005**

DHS Paper File: Muskogee County Multidisciplinary Team Letter to the Court  
The attending physician and physician representative to the multidisciplinary team submitted a letter to the district judge. The following was excerpted from the letter:

As you recall, [sibling 1] had a brother by the name of [sibling 2] who was under my care until his death. There was an episode when the child was under my care in the hospital where it was felt that this child had a hypoxic episode due to the fact that the aunt of the child, Latonya [last name redacted in DHS copy] attempted to suffocate this child while in the hospital. This was not witnessed, however the child did have an episode of apnea whereby he became cyanotic, or turned blue, and his eyes rolled back into his head. At that time he was in the care of his aunt who was watching him in the hospital at that time. After this child was discharged by the hospital and the Department of Human Services had investigated, it was determined that the mother, Angela [last name redacted in DHS copy] was not to leave this child or any other child in the care of Latonya [last name redacted in DHS copy] again. However, some time later, [sibling 2] was unfortunately left by his mother, Angela [last name redacted in DHS copy] in the care of this aunt. The child died on 6/13/03. There has been some discussion that [sibling 1] actually witnessed this event and has had some horrific episodes of nightmares and night terrors secondary to this. [Sibling 1] has been in the State's custody now for over 17 months, well over the 15 month time period where termination is requested.

It is the feeling of the team and especially myself that Angela Warren should not have custody of any of her kids due to her past inability to protect, especially one time resulting in the death of one of her children and also a very grave social situation in which the father of her current children is currently in jail awaiting trial for murder. . .

At the time of this dictation, I have also notified the physicians at EOPC, St. Francis Neonatal Care Unit about the history of this mother where she currently has a newborn child by the name of [sibling 4] and has been there for quite some time due to prematurity secondary to alleged no prenatal care.

**February 24, 2005**

Order Appointing a Court Appointed Special Advocate (CASA)  
A CASA volunteer was appointed by the court to conduct an independent investigation regarding the child [sibling 1] and the family.

## **March 18, 2005**

### **Sixth DHS Referral**

Summary of Allegations: Reportedly, [sibling 1] was left alone with other children while his mother went to the store. Allegedly, [sibling 1] had bruises and scratches on his neck and behind his ears.

Findings: "Services Recommended." According to the Report to District Attorney, Summary / Recommendations:

The allegation of physical abuse could not be substantiated. Due to [sibling 1] and Mrs. Warren stating another child and [sibling 1] got into a fight. Mrs. Warren states she put the children into time out for the incident. The allegation of Lack of Supervision is ruled uncertain. [Sibling 1] states that his mother left him at her apartment with other children while she went to the store. [Sibling 1] could not tell work[er] how old the children were, just that they are big. Mrs. Warren denied that she left the child alone, stating she would not do something this stupid with the watchful eyes of DHS watching her. Services Recommended. Worker recommends that Mrs. Warren continue with her current court ordered Treatment Plan. No further Court Action is requested at this time.

The incident occurred while [sibling 1] was visiting in the home of his mother. [Sibling 1] remained in DHS custody in a kinship foster home.

## **March 22, 2005**

### **Differential Diagnosis**

At the request of DHS child welfare, [sibling 1] was evaluated by a licensed professional counselor and registered play therapist for clinical diagnosis. The primary diagnosis was post traumatic stress disorder (PTSD) and secondarily, oppositional defiant disorder (ODD).

## **April 6, 2005**

### **Seventh DHS Referral**

Summary of Allegations: [sibling 4], four-month-old infant, was released from the neo-natal unit. The child was born after 26 weeks gestation. The mother has an open permanency planning case.

Findings: "Confirm – Court Intervention Requested." According to the Report to District Attorney, Summary / Recommendations:

An investigation was assigned and completed an unannounced home visit was conducted. The home was adequate in meeting the needs of the family. The children in the home were too young to be interviewed. Therefore they were observed. . . Mother appeared knowledgeable and calm in relation to her ability to care for the child appropriately. . . Mother was appropriate in all her care for the child when at the hospital. . . Medical professional stated the child was doing well since arriving at the home. . . Allegations of Neglect, Threat of Harm are confirmed due to the impact of child's age and physical vulnerability. . . Mother currently has an open Permanency Planning case (child fatality) stemming from 2003 in Muskogee County. The child is said to be threatened with substantial harm as a result of mother's history.

A deprived petition was requested. The child was placed in DHS custody. DHS placed the child in the home of the mother, Angela Warren. Sibling 3 (one-year-old) remained in the home (Sibling 3 was not placed in DHS custody.) CHBS was continued in the home. Sibling 1 (four-year-old) remained in DHS custody in a kinship foster home.

### **May 3, 2005**

#### CASA Report to the Court

On May 3, 2005, the appointed CASA worker submitted a report to the court regarding visits with sibling 1, sibling 1's foster mother, two child welfare workers, and sibling 1's natural mother. The following Concerns/Assessments and Recommendations were included:

#### Concerns/Assessments:

CASA is concerned that Ms. Warren has not made any attempt to contact [sibling 1] in the last month.

CASA is concerned about Ms. Warren leaving her children unattended.

#### Recommendations:

CASA recommends [sibling 1] remain where he is with his paternal Aunt.

### **May 27, 2005**

#### DHS Case Contact Note

[Child welfare worker] indicated he had just received a call from [reporter] regarding the Warren children. [The worker] relayed to this worker the mother had just been seen in her mother's car without the children or car seats. The assumption was staffed as to the possibility of the mother allowing the children to have contact [with] "The Sister" – no specifics were provided other than mother was seen in Muskogee. [The worker] stated it was reported to

him the mother was allowing her sister to care for the children. [The worker] and this worker staffed the allegations. [The worker] requested this worker address the family as soon as possible.

## **June 23, 2005**

### **DHS Case Contact Note**

[Worker] contacted [kinship foster mother] and set up visit for tomorrow morning. During the conversation, [kinship foster mother] reported that she has seen Ms. Warren out in the late evening hours without her children. DHS is having concerns about who is caring for the children when Ms. Warren is without them. It has been reported that Ms. Warren's sister has moved back to Muskogee and is living with her mother. Tonya [Latonya, Angela's sister] is the aunt who was caring for [sibling 2] at the time of his death. It has also been reported that Tonya could possibly be pregnant. If this situation is true, it could be very dangerous for the child to be in the care of this mother.

## **June 27, 2005**

### **DHS Case Contact Note**

5:05 p.m. [Child welfare worker], CWS IV, indicated he had just received a call from [child welfare worker], Muskogee County CWS IV, regarding the Warren children. [The worker] relayed to this worker the mother had just been seen in her mother's car without the children or car seats. [The worker] stated it was reported to him the mother allegedly allowing her sister to care for the children. [The worker] and this worker staffed the allegations all based on assumption the sister, Tonya, was living at the maternal grandmother's home. [The worker] requested this worker address the family as soon as possible.

### **DHS Case Contact Note (excerpted)**

Home visit. Worker arrived (5:30 p.m.) and Ms. Warren answered the door. Ms. Warren was addressed with the allegations of allowing the children to be cared for by/left with her sister [Latonya] –now back in the Muskogee area. Ms. Warren was advised the reports indicate she was allowing the children to stay with her sister. . . Ms. Warren adamantly denied she had taken the children to her sister's. Ms. Warren indicated her sister had her own place (with husband or boyfriend) and had not been to visit her sister at the sister's home. Ms. Warren indicated she did not know the exact location of her sister's residence. Ms. Warren concluded she has no contact with her sister.

### **DHS Case Contact Note (excerpted)**

Ms. Warren's mother, the children's grandmother . . . stated Ms. Warren has not been around her daughter – Ms. Warren's sister. [The grandmother] stated, "I told her . . . it was just not a good idea." [The grandmother] stated

she has taken pictures of the children to the sister, but Ms. Warren and the children have not been to visit or in the company of Ms. Warren's sister.

### **August 30, 2005**

#### DHS Case Contact Note

Wk [child welfare worker] received a call from Ms. Warren. Ms. Warren wanted to make sure wk was aware that [father of sibling 1] was in jail with allegations of murder. Ms. Warren wanted wk to know that little [sibling 1] had a visit with his father while he is in jail. Ms. Warren also wanted wk to know that her attorney, . . . informed her that agreeing to guardianship for little [sibling 1] was not a good idea, therefore, Ms. Warren has changed her mind and does not want to give guardianship to [the paternal aunt]. . .

### **September 19, 2005**

#### Post Adjudication Review Board [PARB] Report to Court

The PARB board reported recommendations and findings to the court regarding sibling 1. The board reported the father was "participating" in his treatment plan and recommended, "Continue to work with Father to complete treatment plan."

### **September 20, 2005**

#### DHS Case Contact Note

Adjustment: [sibling1] has adjusted well in his placement. Visitation: There has been no visits from the mother for quite some time. When [sibling 1] is asked about seeing his mother, he cries and says that he does not want to see her. His father is incarcerated in the Muskogee County jail. [The paternal aunt] takes [sibling 1] to the jail on Sunday to visit with his father. So far those visits have been going well. Treatment plan/court: Ms. Warren along with [sibling 1's father] continues to work on their Treatment Plans and they attend all court reviews. . .

### **November 23, 2005**

#### Petition to Terminate Parental Rights

On this date the Assistant District Attorney, Kristin A. Littlefield, filed a petition to terminate the parental rights of Angela Warren and [the father of sibling 1] regarding their son, [sibling 1]. The petition stated, in part:

The parent(s) has/have failed to correct the conditions in which the child/children were found to be deprived and therefore adjudicated such and that at least three (3) months have passed since given the opportunity to correct the conditions.

### **January 24, 2006**

#### **Eighth DHS Referral**

Summary of Allegations according to the incident description report:

Reporter called with concern for two children that are already within the DHS and court system. Reporter said the mother allowed her sister to watch one of her children after being told she should never allow this to happen and this child died in the aunt's care (This happened sometime back, DHS was and is still involved). Reporter said, "Somebody up there (Wagoner Co.) gave this lady her two younger kids back and shouldn't have." Reporter said the police and authorities have been looking for the aunt as she has been gone from Muskogee for awhile. Reporter said he had information that this aunt was at the [apartment complex, address] in Muskogee. Reporter said she may have children with her. Reporter said the two children he is concerned about may be with her at this time as well. Reporter did not know for sure there were children with this lady. Reporter said he was contacting Muskogee PD with this information as well. Reporter was told Wagoner Co. would find out whether the two children in Wagoner Co. were in Muskogee with this aunt or in Wagoner Co. with their mother.

Findings: The referral was screened out [closed without investigation.] Child welfare contacted the children's regular daycare. "The two children in question were at their regular daycare on this date and not with the aunt in Muskogee Co. This referral will be for information purposes only."

### **March 10, 2006**

The District Court of Muskogee County terminated the parental rights of Angela Warren regarding her son, sibling 1.

### **April 4, 2006**

The District Court of Muskogee County terminated the parental rights of [the father of sibling 1] regarding his son, sibling 1.

**October 19, 2006**

The adoption for [sibling 1] was finalized.

**November 13, 2006**

Ninth DHS Referral

Summary of Allegations: Angela Warren disregarded court orders and child welfare recommendations to prevent her children from visiting or staying with her biological sister [Latonya Whitelaw]. One of the three children [Kentrell Warren] she left with the sister suffered a subdural hematoma, respiratory failure, and “suspected non-accidental trauma.” (Report to District Attorney, Referral Synopsis.) Reportedly, the child was transported by life-flight to St. Francis Hospital and placed on life support in the NICU ward.

Findings: “Confirm – Court Intervention Requested.” According to the Report to District Attorney, Summary / Recommendations:

[Child welfare worker] interviewed the biological mother, Angela Warren, and numerous collaterals including the maternal sister and her husband about this incident. It has been determined by the State Office Confirmation protocol for Failure to Protect. [Child welfare worker] considered that the biological mother’s, Angela Warren’s, knowledge of potential risk of harm to the child, her overall attitude about her children’s need for safety, and whether or not a prudent adult could have predicted risk of [harm] to any other [of] her children in the situation. [Child welfare worker] determined that Ms. Angela Warren had knowledge or could have predicted that her children could have been in a high risk situation or with an individual who had a history of abuse, was neglectful or violent behavior and this showed a failure to regard need for safety of her children.

This created a heinous and shocking result for one child, Kentrell Warren, who is now in intensive care in St. Francis Hospital. Other children had been equally at risk during their stay, while Ms. Warren’s sister baby sat them. . . CWS [child welfare worker] notes that the alleged fathers of the children are not actively involved with the children. . . Because of the confirmed findings, [child welfare worker] requests Immediate Court attention and Petition. . .

## **November 17, 2006**

### **Felony Warrants**

A felony warrant was issued on this date charging Angela Warren with felony child neglect. The Arrest Warrant, Information states:

Count 1 Child Neglect ~ a Felony, on or about the 12<sup>th</sup> day of November, 2006, by willfully neglecting her three (3) children K.W. dob 5/31/2006, K.W. dob 5/31/06, and T.S. dob 12/09/2004, by leaving them in the care of her sister Latonya Whitelaw after being admonished in court to not let Latonya Whitelaw care for her children after one of Angela Warren's children died suspiciously under the care of Latonya Whitelaw in 2003.

A felony warrant was issued on this date charging Latonya Whitelaw with felony child abuse by injury. The Arrest Warrant, Information states:

Count 1 Child Abuse by Injury ~ a Felony, on or about the 12<sup>th</sup> day of November, 2006, by willfully and maliciously causing physical and mental injury to K.W., age 5 months, by shaking him causing severe injury to his brain.

Angela Warren and Latonya Whitelaw have been held in custody without bond. Both have been court-ordered to undergo examination for mental competency.