IN THE COURT OF APPEALS
FIRST APPELLATE DISTRICT OF OHIO
HAMILTON COUNTY, OHIO

ESTATE OF G.B., by and through Administrator Blake Maislin,	:	APPEAL NO. C-250376 TRIAL NO. A-1701739
Plaintiff-Appellant,	:	
and	:	*JUDGMENT ENTRY*
MATERNAL GRANDMOTHER,	:	
Plaintiff,	:	
vs.	:	
HAMILTON COUNTY DEPARTMENT OF JOB AND FAMILY SERVICES, et al.,	:	
Defendants,	:	
and	:	
SHAMARA STEPHENS,	:	
KASSI SETTY,	:	
and	:	
LUMADI LAVUSA,	:	
Defendants-Appellees.	:	

This cause was heard upon the appeal, the record, the briefs, and arguments.

For the reasons set forth in the Opinion filed this date, the judgment of the trial court is reversed and the cause is remanded.

Further, the court holds that there were reasonable grounds for this appeal, allows no penalty, and orders that costs be taxed under App.R. 24.

The court further orders that (1) a copy of this Judgment with a copy of the Opinion attached constitutes the mandate, and (2) the mandate be sent to the trial court for execution under App.R. 27.

To the clerk:

Enter upon the journal of the court on 10/23/2026.

Pursuant to App.R. 30, the clerk is directed to serve upon all parties, or their counsel if represented, a copy of the court's judgment and note such action on the docket.

By: Jennifer A. Hensley
Administrative Judge

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KASSI SETTY,	:	
and	:	
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Civil Appeal From: Hamilton County Court of Common Pleas

Judgment Appealed From Is: Reversed and Cause Remanded

Date of Judgment Entry on Appeal: October 23, 2026

FG+G, *Jacqueline Greene* and *Alphonse A. Gerhardstein*, for Plaintiff-Appellant,

Laufman Napolitano, LLC, and *Paul M. Laufman*, and *Michael L. Tranter*, for Defendant-Appellee Shamara Stephens,

Stephen J. Wenke, for Defendant-Appellee Kassi Setty,

Connie Pillich, Hamilton County Prosecuting Attorney, *Pamela J. Sears* and *Bennet S. Weaver*, Assistant Prosecuting Attorneys, for Defendant-Appellee Lumadi Lavusa.

BOCK, Judge.

{¶1} This appeal involves the tragic death of two-year-old G.B., who was murdered by her parents, Andrea Bradley and Glen Bates.[1] Plaintiff maternal grandmother, in her individual capacity and as the then-administrator[2] of the estate of G.B. ("the Estate"), brought wrongful-death and survivorship claims against defendants-appellees Lumadi Lavusa, Shamara Stephens, and Kassie Setty (collectively, "the caseworkers"), who were employed as caseworkers by the Hamilton County Department of Job and Family Services ("JFS").[3] The trial court granted the caseworkers' motions for summary judgment because it determined that they were immune from liability. The Estate appealed.

{¶2} We hold that genuine issues of material fact exist regarding whether the caseworkers' acts or omissions constitute a conscious indifference to, or disregard of, a known or obvious risk of harm to G.B. that was unreasonable under the circumstances—conduct which, if proven, could constitute recklessness under R.C. 2744.03(A)(6)(b) and defeat immunity. We sustain the Estate's assignments of error, reverse the trial court's judgment, and remand the cause to the trial court.

[1] The coroner identified two causes that equally contributed to G.B.'s death: starvation and blunt-force trauma. Because the evidence involving G.B.'s prolonged malnutrition and starvation is sufficient to create a genuine issue of material fact regarding whether the caseworkers acted recklessly for purposes of R.C. 2744.03(A)(6)(b), we confine our analysis to that aspect of the record. Accordingly, we do not address whether the caseworkers' actions or omissions with respect to investigating Bates, including whether he was residing in the home with Bradley and G.B., whether he had a propensity for violence, or whether he was a suitable caregiver, independently create a genuine issue of material fact regarding recklessness.

[2] On June 15, 2018, Blake Maislin replaced maternal grandmother as the administrator of the Estate of G.B., a deceased minor, by order of the Hamilton County Court of Common Pleas, Probate Division. Thus, the plaintiff-appellant in this appeal is the Estate of G.B., by and through administrator Blake Maislin.

[3] Maternal grandmother sued other defendants, but this appeal involves only the three caseworkers.

I. Factual and Procedural History

A. Caseworkers' deficient briefs

{¶3} As a preliminary matter, Stephens's and Setty's appellate briefs are deficient. The briefs do not comply with App.R. 16 because, rather than providing their own statements of fact, they simply direct this court to the statements of fact contained in their summary-judgment motions. But the Rules of Appellate Procedure do not permit parties to incorporate arguments or factual recitations by reference to filings in the trial court. *See Erie Cty. Dept. of Jobs & Family Servs. v. Ray*, 2025-Ohio-2327, ¶ 19 (6th Dist.) (collecting cases). App.R. 16 requires parties' briefs to set forth a statement of facts with citations to the record. And although App.R. 16(B) allows an appellee to omit a statement of facts if satisfied with the appellant's version, appellees wishing to rely on a different factual account must provide their own statements with proper record citations.

{¶4} Because Stephens's and Setty's briefs contain no independent statement of facts, we were required to sift through the summary-judgment record to determine the facts upon which they relied to support their arguments that they were immune from liability. Identifying the portions of the record that support a party's position is the party's responsibility, not the court's. These deficiencies improperly shifted to the court the burden of locating and assembling the evidence necessary to evaluate the parties' arguments and hindered the efficient resolution of this appeal.

{¶5} Setty's summary-judgment motion further impedes our review because it contains no citations to evidence in the record, making it impossible to locate supporting material by reference to that motion. Again, courts are not required to search the record to find evidence supporting a party's position.

B. Procedural history

{¶6} The Estate sued various entities and individuals, including the caseworkers, asserting claims for wrongful death and survivorship.

{¶7} The trial court granted judgment on the pleadings to all defendants. This court affirmed that judgment. *Maternal Grandmother v. Hamilton Cty. Dept. of Job & Family Servs.*, 2020-Ohio-1580 (1st Dist.) ("*Maternal Grandmother I*"). The Supreme Court of Ohio reversed the judgment in favor of the caseworkers and remanded the cause to the trial court. *Maternal Grandmother, Admr. v. Hamilton Cty. Dept. of Job & Family Servs.*, 2021-Ohio-4096 ("*Maternal Grandmother II*").

{¶8} On remand, the caseworkers moved for summary judgment. The trial court granted their motions and entered judgment in their favor, finding that the caseworkers were entitled to statutory immunity because the Estate's evidence failed to establish that the caseworkers' acts or omissions were reckless.

{¶9} The Estate appealed.

C. Facts

1. The juvenile court placed G.B. in JFS's custody immediately after her birth

{¶10} In January 2013, G.B. was born to her parents, Bradley and Bates. G.B. was born full term and weighed eight pounds, eight ounces, placing her in the 84th percentile for weight.

{¶11} Before G.B.'s birth, JFS had obtained temporary custody of Bradley's four other children based on allegations that Bradley had left her children in the care of her five-year-old child, who sustained "multiple marks and bruises as a result of physical discipline at the hands" of Bradley. Bradley signed a voluntary agreement stating that she was unwilling to care for G.B. JFS placed G.B. with her siblings in

foster care.

2. Lumadi Lavusa

a. August 26, 2013 to December 31, 2013

{¶12} In late August 2013, JFS assigned G.B.'s case to ongoing caseworker Lavusa. That same day, JFS moved for the juvenile court to terminate JFS's temporary custody and return the children to Bradley. JFS's motion indicated that Bradley had completed substance-abuse treatment and parenting classes, tested negative on random drug screens, and was treating her mental-health issues with medication and therapy. The children's GAL supported terminating temporary custody, but he noted in his report that "[a] few issues do present." One of these issues was that the children were receiving only "one meal per day during visits" with Bradley.

{¶13} Two days later, Lavusa and Bradley visited the children at the foster parents' home. During the visit, the foster mother told Lavusa she was concerned about the children returning to Bradley's custody. She explained that she often gave Bradley food for the children when Bradley had unsupervised weekend visits with the children because Bradley lacked food in her home. Lavusa told the foster mother that Bradley would receive a food voucher.

{¶14} The juvenile court granted JFS's motion and the children returned to Bradley's custody on September 9, 2013. A protective-supervision order required Bradley to provide JFS reasonable access to her home, maintain sobriety, cooperate with mental-health services, and complete intensive-family-restoration services ("IFRS"). When she returned to Bradley's custody, G.B. weighed 18 pounds and four ounces, placing her in the 82nd percentile for weight for an eight-month-old girl.

{¶15} Four days later, after one of G.B.'s siblings alleged that Bradley was locking the children in a closet as punishment, Lavusa made an unannounced visit to

Bradley's home. (Later, this allegation was deemed unsubstantiated.) While there, Lavusa inspected Bradley's refrigerator, documenting that "there was enough food." Bradley told Lavusa that maternal grandmother had provided Bradley with food and that she had reapplied for food assistance. Bradley told Lavusa that she had been unable to pay her rent for two months because she had stopped receiving benefits.

{¶16} A few days later, Lavusa spoke with a prosecutor about a child-endangerment case that had been filed against Bradley due to the child's allegation. The prosecutor advised Lavusa to visit weekly to ensure the children's safety and to obtain supplemental food vouchers for Bradley.

{¶17} A little more than one week after the children had returned to Bradley's care, Lavusa made a planned visit to Bradley's home. Bradley told Lavusa that her food assistance had not "kicked in yet" despite "them showing that they have been posted." Lavusa said she would follow up with the food-assistance worker and directed Bradley to food pantries. Bradley assured Lavusa that G.B. "had plenty of food." But Bradley was lying: Lavusa inspected Bradley's refrigerator to find that there was no food inside it. Bradley signed a release of information for G.B. to participate in a program called "Help Me Grow." Lavusa instructed Bradley to keep her updated about the status of Bradley's food assistance.

{¶18} Three days later, Lavusa returned for an unannounced home visit. Bradley's food assistance had still not "rolled over on her card." Lavusa documented that Bradley had enough food for the night "as evidence[d] by canned foods in the cabinet." Bradley told Lavusa she was in the process of enrolling the children at Walnut Hills Medical Center for their health-care needs. Lavusa documented her intention to follow up with the medical center to confirm the children were enrolled.

{¶19} During an October 2013 visit, Lavusa observed Bradley giving G.B. a

bottle. Bradley told Lavusa that she had a WIC[4] appointment the next day and the children were scheduled for doctors' appointments in November. At a visit later in October, Lavusa documented (1) she told Bradley that an IFRS worker had praised Bradley as very compliant, (2) Bradley represented that she was continuing to take her medication, "which really helps stabilize her," (3) the children appeared "healthy and happy," (4) G.B. "is fairing along well too," and (5) Bradley told Lavusa that despite G.B. sometimes pushing the bottle away, "for the most part she is feeding well."

{¶20} At a November 2013 visit, Bradley told Lavusa that G.B. had begun to crawl and that Help Me Grow was visiting at the end of the month to evaluate G.B. and another child.

{¶21} In December 2013, Lavusa learned that Bradley was seven months pregnant and had not disclosed this to JFS. Lavusa visited later that month, and Bradley confirmed that she was pregnant and Bates was the father. Further, Bradley told Lavusa that Help Me Grow planned to work with G.B. to help her develop motor and verbal skills.

{¶22} After Bradley regained custody of her children, G.B. began losing weight. In September 2013, when G.B. was placed in Bradley's custody, G.B. weighed 18 pounds, four ounces, which placed her in the 82nd percentile for weight for her age. But just months later, in December 2013, G.B. had lost a significant amount of weight. G.B. weighed 16 pounds and 12 ounces, placing her in only the fifth percentile for weight for her age. Lavusa was the family's J.F.S. caseworker during that entire period. According to the coroner who conducted G.B.'s autopsy, it was during this time that G.B. began to experience starvation.

[4] WIC is the United States Department of Agriculture's "Special Supplemental Nutrition Program for Women, Infants, and Children."

b. January 2014 through May 2014

{¶23} At an early January 2014 visit, Bradley told Lavusa that she continued to take her mental-health medication and had an upcoming therapy session. Further, Bradley said that the children were up to date on their doctors' appointments and Help Me Grow was visiting twice a month to work with G.B.

{¶24} At a February 2014 home visit, Lavusa observed no food in Bradley's refrigerator other than a gallon of milk, which one of Bradley's other children reported was for G.B. Bradley told Lavusa that she ran out of food assistance, so she and the children were eating at restaurants. Lavusa suggested that Bradley make use "of the free store" when her food assistance ran out. Bradley reported to Lavusa that a Help Me Grow worker told her that G.B. had "very low muscle tone" and was concerned that G.B. was more than a year old but could not walk.

{¶25} Later that month, Bradley took G.B. to the emergency department at Cincinnati Children's Hospital Medical Center ("Children's"). Bradley reported to medical personnel that G.B. had been "standing on a learning table and fell off backward," hitting her head on a toy. A nurse noted a "large boggy spot" and a "boggy bruise" on G.B.'s forehead. Further, the nurse observed that G.B. "appears very small for her age and is very somnolent in exam room" and believed the doctors should rule out abuse. But a resident physician's note described G.B. as appearing "well-developed and well-nourished." At the hospital, G.B. weighed 16 pounds and 12 ounces, which placed her in the zero percentile for weight for her age. Children's discharged G.B. without documenting any abuse inquiries or concerns.

{¶26} The next day, Lavusa visited Bradley and documented that G.B. was "not looking well" and "appears to have lost some weight." Bradley told Lavusa that G.B. "has been sick with a virus" and that she had taken G.B. to the emergency department.

Bradley told Lavusa that G.B. weighed "about 17 pounds," was "eating well," and G.B.'s doctor had told Bradley that G.B. was "in the right weight range for her age." Bradley also claimed that G.B. had attended her one-year pediatrician appointment and was up to date on her vaccinations. (The coroner could find no record of a one-year medical appointment.) Lavusa's notes said G.B. "presents as being small in stature and underweight" and Bradley "presents as not understanding the child's development in relation to the child's age." Lavusa did not document G.B.'s forehead bruise or injury.

{¶27} In her deposition, Lavusa could not recall following up with G.B.'s medical providers to confirm whether G.B. attended a one-year appointment or if G.B.'s doctors believed G.B.'s weight was on track. Lavusa agreed that had she contacted G.B.'s medical providers, she would have documented doing so. But G.B.'s JFS file contained no documentation that Lavusa attempted to contact the providers.

{¶28} In mid-March 2014, maternal grandmother took G.B. to the emergency department at Children's because G.B. was having difficulty breathing. Children's staff noted that G.B. appeared "very quiet. Not interactive during exam," but otherwise was "well-developed and well-nourished." Children's, however, noted that G.B. had low muscle tone and referred her to neurology. At this point, G.B. weighed 16 pounds, 7.7 ounces, which again placed her in the zero percentile for weight. Lavusa did not know about this hospital visit.

{¶29} At a late-March 2014 visit, Lavusa documented that G.B. had "gained some weight as evidenced by [Lavusa] lift[ing] her in her arms."

{¶30} In April 2014, a Help Me Grow worker called Lavusa and reported that Bradley had missed G.B.'s February 2014 appointment without notification and had cancelled the next-scheduled appointment. The same day that she received the call, Lavusa visited Bradley and documented that G.B. was pulling herself up to stand on a

couch. Bradley claimed to have forgotten about the Help Me Grow appointments she missed. Bradley told Lavusa she would be restarting therapy in six weeks and had resumed taking her medications after her youngest child was born. Later in April, Bradley reported that G.B. had another Help Me Grow appointment and she was taking her medication.

{¶31} In May 2014, Lavusa and her supervisor, Mary Ayoki, closed Bradley's case. As a result, no one from JFS observed Bradley's home, G.B., or the other children between May and December 2014.

3. Children's admits G.B., prompting a neglect report

{¶32} On December 4, 2014, Bradley took G.B. to Children's, which admitted G.B. for an 11-day stay. The medical team diagnosed G.B. with failure to thrive.

{¶33} Stacey Litman-Padnos, a social worker employed by Children's, documented that Bradley had reported limiting G.B.'s food because she believed G.B. was overweight. Bradley also told Litman-Padnos that she was not taking her medication or attending therapy. G.B. weighed 17 pounds and 4.8 ounces, placing her in the zero percentile.

{¶34} Litman-Padnos reported Bradley to 241-KIDS on December 9, 2014. She told the JFS intake worker that Bradley admitted to restricting G.B.'s food because she believed G.B. was overweight and that G.B. had not received "any medical care since she left foster care."

{¶35} Litman-Padnos contacted WIC, which informed her that at a July 2014 WIC appointment, WIC employees were concerned about G.B.'s weight and wanted G.B. to return in September. Bradley did not bring G.B. back to the WIC office.

{¶36} Litman-Padnos explained that Children's doctors had not found a medical explanation for G.B.'s failure to thrive, leading her to suspect that G.B.'s

condition was caused by "malnutrition and restriction of food." Litman-Padnos believed Bradley had a "warped view on what the baby should look like" and "seemed shocked" when Litman-Padnos told her that a baby's legs should have fat on them.

4. Shamara Stephens

{¶37} JFS assigned Stephens to investigate Bradley's neglect. JFS provided Stephens with an "Intake Narrative," which included Litman-Padnos's report and JFS's history with Bradley, detailing past allegations. After being assigned the case, Stephens called her supervisor, Nancy White, to discuss failure to thrive.

{¶38} On December 10, 2014, Stephens spoke with Litman-Padnos, who was "very concerned about [G.B.] as well as her size and development," noting that G.B. was "significantly underweight" and unable to walk. Litman-Padnos told Stephens she suspected that Bradley was "intentionally mistreating [G.B.] and she is fearful of allowing the child to return to the home." Stephens documented that Litman-Padnos had been unable to provide a "concrete" reason for her fear. But Litman-Padnos explained that there was no "medical reason for the failure to thrive so the only other conclusion is neglect." And Litman-Padnos stressed to Stephens the importance of having a "good/safe discharge plan in place before [G.B.] can go home."

{¶39} With G.B. still in the hospital, Stephens visited Bradley at her home. Bradley told Stephens that she had believed G.B. was overweight and admitted "that maybe she was not giving the child the nutrients she needed but denies it was intentional." Stephens's visit notes suggest that Bradley confirmed she was not engaged in any mental-health services. Finally, her notes do not indicate that she spoke with any of Bradley's other children during her visit and a JFS "Post-Death Summary" states that Stephens left "without any determination about the children's safety nor any information to rule out the present danger threats identified in the

hotline. No action was taken."

{¶40} Before G.B.'s discharge, Stephens told Litman-Padnos that JFS lacked "enough information to prevent [Bradley] from taking her child home once she is ready for discharge." Stephens asked Litman-Padnos if G.B. had gained any weight while in the hospital. Litman-Padnos explained that G.B. had gained one pound during her admission, which was "no where [sic] near what they were expecting." According to the JFS Post-Death Summary, there was "no documentation to support the decision to allow [G.B.] to be discharged [to] her mother."

{¶41} Children's discharged G.B. on December 15, 2014. JFS provided G.B.'s discharge summary to Stephens, which indicated that Bradley had been feeding nearly two-year-old G.B. "approximately 8 oz of Similac + 2-3 small bowls of cereal. No solids given due to choking on food."

{¶42} Stephens dropped by the house a week later to deliver Christmas gifts and could not remember if she saw any of the children but explained this was not a "home visit."

{¶43} Two weeks later, Stephens returned to Bradley's home and documented that Bradley told her G.B. had gained three pounds since her hospital admission. G.B. was napping and was not in the room at the time. Later, however, Stephens observed Bradley dressing G.B. and was "shocked at her appearance. The child is significantly underweight and has very glossy eyes. She was not observed moving or making any sounds." Bradley attributed G.B.'s "despondent behavior . . . to the fact that she had just been woke up from a nap" and told Stephens that G.B. had a WIC appointment the next week and would receive a prescription for PediaSure. Bradley also told Stephens that G.B. had been seen at a medical clinic after her discharge from Children's and was scheduled to return to the clinic once she had begun drinking

PediaSure. Stephens spoke with Bradley's other children, who reported that they were not denied food.

{¶44} The next day, January 6, Stephens made referrals for Bradley for a diagnostic assessment and for "Intensive Family Intervention Services." Stephens also initiated transferring Bradley's case to an ongoing caseworker "to ensure that the medical health needs of [G.B.] are properly met and that [Bradley] re-engages in the appropriate mental health treatment."

{¶45} Two days later, Stephens completed a "Safety and Family Assessment" for Bradley's case. She wrote that there "are no active safety threats at this time but there is a concern that [Bradley] is no longer under a mental health doctor's care and it may have an effect on her parenting." Stephens noted that she was "concern[ed]" that Bradley thought G.B. was overweight when she returned from foster care and questioned whether Bradley was "intentionally withholding food from the child." Stephens determined that none of Bradley's children could protect themselves and the "final level of risk for this family is high." She also found the neglect allegation related to G.B. to be "indicated."[5] Although Stephens believed that G.B. had "not received any serious inflicted physical harm at this time," she noted that G.B. was "significantly underweight for age [and] at this time there is no medical reason." Despite concerns with G.B.'s weight, Stephens reported that Bradley had the ability to protect her children and she was "more than capable" of meeting the children's basic needs.

{¶46} Stephens also denied that Bradley was symptomatic for a mental illness

[5] The record shows that a report is "indicated" if there is "circumstantial or other isolated indicators of child abuse or neglect lacking confirmation; or a determination by the caseworker that the child has been abused or neglected based upon completion of an assessment/investigation." A report is "substantiated" if "there is an admission of child abuse or neglect by the person(s) responsible; an adjudication of child abuse or neglect; or other forms of confirmation deemed valid by" JFS, which includes a nonaccidental injury confirmed by a medical provider with expertise in diagnosing maltreatment or written reports/records from service providers.

that might place a child in immediate danger but documented that Bradley had stopped seeing a mental-health provider. Under a space asking whether a caretaker had "an unconvincing or insufficient explanation for the child's serious injury or physical condition," Stephens indicated, "No," but then documented that Bradley restricted G.B.'s consumption of solid foods due to concerns about choking and G.B.'s hospital visit resulting in the failure-to-thrive diagnosis. Stephens's supervisor, Nancy White, signed off on Stephens's assessments.

5. Kassi Setty

{¶47} On January 14, 2015, Stephens and Setty participated in a conference to transfer Bradley's case to Setty, the assigned ongoing caseworker. Setty testified in her deposition that this meeting lasted five minutes, but she was aware that G.B. had been diagnosed with failure to thrive. Stephens gave Setty Bradley's physical file during the meeting. That file included all prior "Activity Log Reports" ("ALRs") about Bradley's case.[6] Setty could not recall if she had read Bradley's file beyond "briefly" reviewing the last few ALRs. And during her deposition, Setty stated that she had been unaware that G.B. had been hospitalized.

{¶48} Six days later, Stephens conducted an unannounced home visit. She did not document seeing any of the children but provided Bradley with a Kmart voucher and confirmed Bradley's availability for a joint home visit with Setty the following day.

{¶49} A week after Stephens transferred the case to Setty, the caseworkers visited Bradley's home together. Setty did not document anything about the visit.

{¶50} Setty's next home visit was scheduled for four weeks later, on February 18, 2015. But Setty called Bradley to cancel that visit due to snow and rescheduled for

[6] Activity Log Reports are notes created by caseworkers that are stored within the Statewide Automated Child Welfare Information System ("SACWIS").

February 26. But Setty did not visit that day. Setty had pushed that visit to later in the day and could not find Bradley's house because it was too dark outside. Setty and Bradley agreed to reschedule the appointment for the next week.

{¶51} In early March, Setty attempted an unannounced home visit, but Bradley was not home.

{¶52} Finally, on March 4, 2015, Setty succeeded in visiting Bradley. Setty referred Bradley, who had stopped taking mental-health medication, to mental-health services. Bradley told Setty that G.B.'s Help Me Grow services were "'closed out' stating that 'everything was fine.'" Setty documented her intention to verify this information. Bradley told Setty she had taken G.B. to the WIC office, where personnel said G.B. was "'doing great.'" Further, Bradley told Setty that G.B.'s pediatrician said G.B. "'will catch up,'" and G.B.'s next pediatrician appointment was in May. Setty documented that G.B. appeared sleepy during the visit "and was falling in and out of sleep."

{¶53} Although Setty testified that she had attempted to verify Bradley's representations about Help Me Grow and WIC, she conceded that if she had sent a request for information, she likely would have documented the request, which would be in the file. Setty did not attempt to contact G.B.'s doctor because she did not know who it was. Setty never reviewed any of G.B.'s medical records or contacted G.B.'s medical providers. She never asked anyone about G.B.'s weight, whether G.B. was being weighed, or how or when G.B. was fed. Moreover, Setty made "[v]ery little" attempts to observe G.B.'s weight during her visit, and she never asked about or attempted to observe any part of G.B.'s body.

{¶54} Three weeks later, on March 26, 2015, Setty attempted to visit Bradley. Bradley was not home, so Setty left a visitation receipt on the door requesting Bradley to call to schedule a visit.

6. G.B.'s death and autopsy

{¶55} On March 29, 2015, Bradley brought G.B. to the emergency department at Children's. G.B. was dead when she arrived and was covered in numerous visible injuries, including a head injury.

{¶56} Hamilton County Deputy Coroner Dr. Schott conducted an autopsy on G.B. the following day. She ruled G.B.'s death a homicide and attributed it to two equal causes: (1) battered-child syndrome with acute and chronic intracranial hemorrhages, and (2) starvation. Dr. Schott explained that "the effects of the starvation and the blunt impacts were both equally important in the cause of death." She reported, "the blunt force injuries could have stood alone as a cause of death, and that the starvation could have stood alone as a cause of death, but they are both two components of child abuse."

{¶57} The autopsy showed that G.B., who was approximately 26 months old when she died, weighed only 13 pounds and 14.2 ounces and was 28 inches tall, placing her in the zero percentile for both height and weight for her age. Dr. Schott stated that G.B. "definitely" was experiencing starvation in December 2013. She explained that this starvation caused G.B.'s failure-to-thrive diagnosis. Dr. Schott's autopsy report showed that G.B. had abdominal distension, thinned hair, generalized muscle wasting, loss of subcutaneous fat, puffy feet, loose skin, and general malnutrition, all of which were present during G.B.'s December 2014 hospital admission.

7. Investigation and conviction of Bradley and Bates

{¶58} The State charged Bates and Bradley with G.B.'s murder. Bradley pleaded guilty to murder and is serving a 15-year-to-life sentence in prison. Bates was convicted of aggravated murder and sentenced to death, but his conviction was reversed by the Ohio Supreme Court. *See State v. Bates*, 2020-Ohio-634. Bates later pleaded guilty to amended charges.

{¶59} After G.B.'s death, JFS performed a safety assessment for Bradley's other children. JFS learned that Bradley never took G.B. to any weekly weight checks after December 17, 2014.

II. Analysis

{¶60} On appeal, the Estate raises three assignments of error, which assert that the trial court erroneously granted summary judgment to Lavusa, Stephens, and Setty. Under each assignment of error, the Estate presents two issues for review: (1) whether the trial court improperly defined recklessness under R.C. 2744.03(A)(b)(6); and (2) whether genuine issues of material fact preclude summary judgment.

{¶61} In entering summary judgment in favor of the caseworkers on the issue of immunity, the trial court concluded that the caseworkers' conduct did not rise to the level of recklessness. The trial court determined that Lavusa and Stephens followed up with Bradley through visits, assisted her with resources, and "made attempts" to confirm her compliance with JFS directives. It is unclear from the record upon what facts the court relied to find that Lavusa and Stephens "made attempts" to confirm Bradley's compliance, other than documenting Bradley's representations that she was complying.

{¶62} The trial court appeared to be more critical of Setty's conduct. It observed, "[w]hether due to inexperience or lack of training, it appears Setty was unprepared for the role as a social worker" and that her notes "leave much to be desired and make it difficult to determine what actions she took." Nevertheless, the court found no evidence that Setty observed abuse or neglect or possessed knowledge that her conduct would "in all probability result in injury."

{¶63} We first address and set forth the proper definition of "reckless" in the context of statutory immunity. Then we address whether the caseworkers were

entitled to summary judgment.

A. De novo review

{¶64} This court reviews a trial court's decision granting summary judgment de novo. *Branson v. Fifth Third Bank, N.A.*, 2025-Ohio-4396, ¶ 28 (1st Dist.).

{¶65} Trial courts shall grant summary judgment if "(1) there are no genuine issues of material fact, (2) the movant is entitled to judgment as a matter of law, and (3) when viewing the evidence most strongly in the nonmovant's favor, reasonable minds can come to one conclusion, and that conclusion is adverse to the nonmovant." *Id.* at ¶ 29, citing Civ.R. 56(C).

{¶66} The party seeking summary judgment bears the initial burden to explain the basis for summary judgment by pointing to admissible evidence in the record demonstrating that no genuine issue of material fact exists on the essential elements of the nonmoving party's claims. *Weckel v. Cole + Russell Architects, Inc.*, 2024-Ohio-5111, ¶ 34 (1st Dist.), quoting *Dresher v. Burt*, 75 Ohio St.3d 280, 293 (1996). Once the movant meets this burden, the burden shifts to the nonmovant to "set forth specific facts showing that there is a genuine issue for trial." Civ.R. 56(E).

{¶67} "'Summary judgment is admittedly a drastic device' because it 'cuts off a party's right to present [her] case to the jury.'" *Johnson v. Munther*, 2005-Ohio-3641, ¶ 56 (5th Dist.), quoting *Dupler v. Mansfield Journal Co.*, 64 Ohio St.2d 116, 120 (1980). Courts reviewing summary-judgment motions may not weigh the evidence; rather, they must view the facts and all reasonable inferences in favor of the nonmoving party. *Smathers v. Glass*, 2022-Ohio-4595, ¶ 32. "When factual ambiguities exist, inferences must . . . be resolved in favor of the nonmoving party." *Id.*

B. Political subdivision immunity and the "recklessness" exception

{¶68} Ohio law generally grants political subdivisions and their employees immunity from lawsuits and liability. *Maternal Grandmother II*, 2021-Ohio-4096, at ¶ 7, citing R.C. 2744.02(A)(1) and 2744.03(A)(6). "That immunity is not absolute, however." *Id.* Employees may be liable for acts or omissions within the scope of their employment when their conduct is reckless. *Id.*, citing R.C. 2744.03(A)(6)(b). Liability cannot be imposed for mere negligence. *Anderson v. City of Massillon*, 2012-Ohio-5711, ¶ 23.

C. "Recklessness" includes the conscious disregard of a known or obvious risk

{¶69} In its entry granting summary judgment to the caseworkers, the trial court, citing *O'Toole v. Denihan*, 2008-Ohio-2574, defined recklessness as "a perverse disregard of a known risk." It concluded that the caseworkers neither knew of nor perversely disregarded the risk that G.B. would be harmed by her parents. The Estate contends that this formulation improperly required proof of actual, subjective knowledge and failed to account for an obvious risk that a reasonable person in the caseworkers' position would have recognized. We agree that, to the extent the trial court confined its analysis to risks about which the caseworkers had actual knowledge, it applied an unduly narrow standard.

{¶70} In *Thompson v. McNeill*, 53 Ohio St.3d 102 (1990),[7] the Ohio Supreme Court adopted the Restatement definition of reckless conduct. *Id.* at 104; *see* 2 Restatement of the Law 2d, Torts, § 500, at 587 (1965). Under that definition, a person is reckless when the person performs an act, or intentionally fails to perform a required

[7] While not overruling *Thompson*, the Supreme Court of Ohio rejected dicta in *Thompson* indicating that "willfulness," "wantonness," and "recklessness" were interchangeable terms. *Anderson* at ¶ 31.

act, while "*knowing or having reason to know*" of facts that would lead a reasonable person to recognize both an unreasonable risk of physical harm to another and a risk that is substantially greater than that necessary to establish negligence. (Emphasis added.) *Id.* at 105, quoting 2 Restatement, § 500; *see Anderson* at ¶ 34 (*Thompson* adopted the Restatement's definition of reckless).

{¶71} The Court later described recklessness in *O'Toole* as a "perverse disregard of a known risk." *O'Toole* at ¶ 73. But *O'Toole* did not displace the broader definition adopted in *Thompson*. Indeed, immediately before offering that shorthand formulation, the Court quoted *Thompson's* knowing-or-having-reason-to-know standard. Read in context, "perverse disregard of a known risk" distills the governing rule; it does not restrict recklessness to risks proven through the actor's actual, subjective awareness.

{¶72} This conclusion is confirmed by *Anderson*. There, the Court clarified that willful, wanton, and reckless conduct describe distinct degrees of culpability and are not interchangeable. *Anderson*, 2012-Ohio-5711, at ¶ 3. The Court defined reckless conduct as the "conscious disregard of or indifference to a known or obvious risk of harm to another that is unreasonable under the circumstances and is substantially greater than negligent conduct." *Id.* at ¶ 34. The inclusion of an "obvious" risk preserves the objective component of the *Thompson* standard: the relevant risk need not have been expressly acknowledged by the actor if the circumstances made that risk apparent to a reasonable person in the actor's position.

{¶73} The Ohio Supreme Court's subsequent decisions consistently read these formulations of recklessness together. In *A.J.R. v. Lute*, 2020-Ohio-5168, the Court cited both *O'Toole's* perverse-disregard-of-a-known-risk formulation and *Anderson's* definition involving a "known or obvious risk." *Lute* at ¶ 17. In *Smathers v. Glass*,

2022-Ohio-4595, the Supreme Court of Ohio considered R.C. 2744.03's recklessness exception in a lawsuit filed against social workers after a child's death and again defined reckless conduct as the conscious disregard of or indifference to a known or obvious, unreasonable risk substantially greater than negligence, while also recognizing *O'Toole's* shorthand description. *Id.* at ¶ 33. And in the Supreme Court's opinion reversing this Court's judgment in *Maternal Grandmother I*, 2020-Ohio-1580 (1st Dist.), the Supreme Court applied *Anderson's* known-or-obvious-risk formulation. *See Maternal Grandmother II*, 2021-Ohio-4096, at ¶ 7. These decisions show that *Thompson*, *O'Toole*, and *Anderson* are complementary, not inconsistent.

{¶74} Accordingly, we hold that a person's conduct may be "reckless" in the context of R.C. 2744.03(A)(6)(b) when the person acts, or fails to act despite having a duty to do so, with "conscious disregard of or indifference to a known or obvious risk of harm to another that is unreasonable under the circumstances and is substantially greater than negligent conduct." *See Smathers* at ¶ 33, quoting *Anderson* at ¶ 34; *Maternal Grandmother II* at ¶ 8. In other words, for a government employee's conduct to constitute "recklessness," thus constituting an exception to statutory immunity, the employee need not have had actual knowledge of a risk; rather, as to whether the employee had sufficient knowledge of the risk, it is enough that a reasonable person would have known and appreciated the risk. *See* 2 Restatement, § 500, Comment c; *see also Baab v. Medina City Schools Bd. of Edn.*, 2019-Ohio-510, ¶ 14 (9th Dist.); *Al-Jahmi v. Ohio Athletic Comm.*, 2022-Ohio-2296, ¶ 100 (10th Dist.); *Mercer v. Athens Cty.*, 72 F.4th 152, 165 (6th Cir. 2023) (observing that "'Ohio law does not require a showing or finding that a person had actual, subjective knowledge of a known or obvious risk of harm to conclude that he acted recklessly.'").

D. The evidence presents questions of fact involving whether the caseworkers acted recklessly

{¶75} "[C]aseworkers tasked with ensuring the safety and well-being of Ohio's children face some of the biggest challenges in our communities: addiction, mental-health disorders, poverty, and trauma." *Smathers* at ¶ 1. R.C. 2744.03 "recognizes that a court should not use hindsight to judge the difficult decisions made by children's-services workers" and shield them from accusations of negligence in their work. *Id.* at ¶ 1-2. R.C. 2744.03 strikes a balance between "the need to protect children's-services workers so that they may do their job without fear of being sued [and] the need to ensure that children are not harmed because of a children's-services worker's wanton or reckless conduct." *Id.*; *see* R.C. 2744.03(A)(6).

{¶76} Whether a political subdivision employee is entitled to statutory immunity "is an issue that appropriately may be decided on a motion for summary judgment." *Smathers*, 2022-Ohio-4595, at ¶ 3. Courts, however, should grant summary judgment based on statutory immunity only where the government employee's evidence is "*so one-sided* that the party claiming immunity should prevail as a matter of law." (Emphasis added.) *Id.* Courts are cautioned that because "this determination requires an application of the immunity statute to undisputed facts, the court must be careful not to step into the role of fact-finder." *Id.*

1. Ohio courts have found recklessness to present a jury question in some cases and resolved the issue as a matter of law in others

{¶77} The parties rely on cases addressing whether children's-services caseworkers are entitled to judgment as a matter of law based on statutory immunity, including whether an exception to immunity under R.C. 2744.03(A)(6) applies. These cases demonstrate that whether an agency employee acted recklessly is necessarily fact-specific and depends on the circumstances that the employee knew or should have

known and the employee's response to those circumstances.

{¶78} In *Smathers*, the Supreme Court of Ohio reversed a summary judgment in favor of children-services employees responsible for overseeing a two-year-old girl who later died from abuse or neglect. *Smathers* at ¶ 4. There, the grandmother had repeatedly reported concerns about the child's mother, and the child was later hospitalized because medical providers suspected abuse after the child collapsed while in the grandmother's care. *Id.* at ¶ 7, 12. Despite the hospital's concerns of abuse, the agency cleared the child for discharge to her parents. *Id.* at ¶ 20.

{¶79} The Court concluded that a reasonable factfinder could find the employees had acted recklessly based on, among other things, assuming that the grandmother could protect the child despite later observations that the child was with her mother again; clearing the child for discharge based on an arguably inconsistent notation in the medical records, despite documented evidence of abuse; delaying in obtaining and following up on the child's medical records; failing to verify the child's whereabouts; and failing to address or document dangerous conditions in the home. *Smathers*, 2022-Ohio-4595, at ¶ 36-45. Construing the evidence in the grandmother's favor, the Court held that a reasonable factfinder could conclude that the employees acted recklessly or wantonly in failing to protect the child from the risk of abuse or neglect.

{¶80} In *O'Toole*, the Supreme Court upheld a summary judgment in favor of a children-services supervisor who oversaw a caseworker assigned to a family in which a child died from abuse. *O'Toole*, 2008-Ohio-2574, at ¶ 1. After the child's daycare reported injuries, the caseworker interviewed the daycare staff, the child, and the mother, and the caseworker and supervisor implemented a safety plan. *Id.* at 15-26. The supervisor reviewed the evidence and, considering the mother's cooperation, the

clean and safe home, her favorable background check, and the safety plan, the supervisor determined that removal was not warranted. *Id.* at ¶ 29. The Court held that these circumstances did not amount to reckless conduct. *Id.* at ¶ 76.

{¶81} In *Jackson v. Butler Cty. Bd. of Cty. Commrs.*, 76 Ohio App.3d 448 (12th Dist. 1991), the Twelfth District affirmed a summary judgment in favor of a children-services caseworker after a child died from abuse by her father following reunification. *Id.* at 450-451. The caseworker had visited the father's home, spoken with the father's partner several times, followed up regarding the child's medical condition, and attempted to schedule another home visit six weeks after her initial visit. *Id.* at 451. Although an evaluation report did not portray the father as "the ideal parent," it contained no indication that he posed a risk of physical violence. *Id.* at 455. The court concluded that the caseworker's conduct, including her single home visit, repeated conversations, and encouragement to seek medical care, did not constitute recklessness. *Id.* at 456.

{¶82} Unlike in *O'Toole* and *Jackson*, where the employees had taken affirmative steps to address the concerns presented to them, the evidence here, construed in the Estate's favor, would permit a reasonable factfinder to conclude that the caseworkers failed to respond to significant and reasonably identifiable risks to G.B, similar to the caseworkers in *Smathers*. The caseworkers failed to demonstrate that the evidence "is so one-sided that the [caseworkers] should prevail as a matter of law." *See Smathers*, 2022-Ohio-4595, at ¶ 3. Accordingly, we hold that none of the caseworkers are entitled to judgment as a matter of law.

2. Lavusa

{¶83} The Estate argues that a jury could find Lavusa reckless for failing to ensure that Bradley had adequate food for G.B. and for failing to contact G.B.'s medical

providers regarding her weight.

{¶84} When Lavusa took over the case in August 2013, JFS and the juvenile court were in the process of returning Bradley's children to her under protective supervision. G.B. had been born full-term, had no medical conditions affecting weight gain, and in August 2013 weighed 18 pounds and four ounces, placing her in the 82nd percentile in weight for a seven-month-old baby.

{¶85} During her first month as Bradley's caseworker, Lavusa had multiple signs that should have warned her that Bradley did not keep enough food in her home to feed her children. The children's foster mother told Lavusa that Bradley lacked food for the children and the foster mother supplied the food for unsupervised weekend visits. The children's GAL documented that Bradley fed the children only one meal per day. Days after Bradley regained custody of the children, Lavusa inspected Bradley's refrigerator and noted there was "enough food," but she did not document whether Bradley had formula to feed G.B. During visits on September 20 and 23, Bradley claimed her food-assistance benefits had not yet begun, despite the records showing that the benefits had been issued. Lavusa said she would follow up with the food-assistance worker and directed Bradley to food pantries, but the record contains no documentation that she did so. During one visit, Bradley lied to Lavusa, saying she had plenty of food for the children, but there was no food in the refrigerator. Days later, Lavusa noted only canned goods in the home, again without confirming whether Bradley had formula to feed G.B.

{¶86} From October through December 2013, Lavusa made multiple visits to Bradley's home, but she never documented whether she had food or formula available for the children. Meanwhile, WIC records show that by December 11, 2013, only three months after Bradley regained custody of her children, G.B. had dropped from the

82nd percentile to the fifth percentile in weight, weighing only 16 pounds, 12 ounces. The coroner testified that G.B. had begun starving by that time. Lavusa's January 2014 visits likewise contained no documentation regarding food.

{¶87} In February 2014, Lavusa again observed an empty refrigerator, except for a gallon of milk that another child said was for G.B. Bradley reported her food-assistance benefits had run out and relayed concerns from a Help Me Grow worker about G.B.'s low muscle tone and inability to walk.

{¶88} On February 17, 2014, Bradley took G.B. to the emergency department at Children's after G.B. sustained an injury to her head. A nurse noted that G.B. appeared "very small for her age," was somnolent, and suggested ruling out abuse. Although a resident described G.B. as "well-developed and well-nourished," G.B. weighed only 16 pounds, 12 ounces.

{¶89} The next day, Lavusa visited Bradley and documented that G.B. was "not looking well," appeared to have lost weight, and looked "small in stature and underweight." Bradley claimed that the doctor was unconcerned and that G.B. had attended her one-year appointment. The coroner found no record of such an appointment. Lavusa neither contacted medical providers to confirm Bradley's assertions about G.B.'s condition nor attempted to obtain G.B.'s hospital records.

{¶90} Lavusa continued visiting Bradley in March and April 2014, but she did not document food availability. Despite medical records showing G.B.'s continued weight loss, Lavusa wrote on March 31 that G.B. had "gained some weight," based solely on Lavusa lifting G.B. In April, Help Me Grow informed Lavusa that Bradley had not appeared with G.B. at her February and March appointments.

{¶91} In May 2014, Lavusa closed the case, concluding that Bradley was meeting her children's basic needs. As a result of Lavusa's closing Bradley's case, no

one from JFS observed G.B. between May 2014 and December 2014, when G.B. was admitted to Children's for 11 days with a failure-to-thrive diagnosis.

{¶92} Taken together, the evidence shows that despite Lavusa helping Bradley obtain food assistance, Lavusa knew when she was assigned to the case that Bradley struggled with food insecurity and Lavusa repeatedly encountered an empty or inadequately stocked refrigerator. Yet, from September 2013 through January 2014, when G.B. still required formula, Lavusa never documented whether Bradley had formula available. After G.B. turned one, Lavusa documented the availability of food only once, despite repeatedly visiting a home where food was scarce. By December 2013, G.B. had lost a significant amount of weight—she dropped from the 82nd percentile to the fifth percentile in weight. The coroner confirmed that by December 2013, G.B. had begun experiencing starvation.

{¶93} A reasonable jury could find that Lavusa's failure to adequately investigate or address G.B.'s nutritional needs, despite these circumstances, demonstrated a conscious disregard of an obvious risk to G.B.'s health.

{¶94} Moreover, the evidence raises a question of fact as to whether Lavusa acted recklessly by failing to contact G.B.'s medical providers, WIC, Help Me Grow, or other service providers to confirm Bradley's assertions about G.B.'s health. In her deposition, Lavusa acknowledged that caseworkers must make collateral contacts. Yet, after observing that G.B. appeared unwell and underweight on February 18, 2014, Lavusa relied solely on Bradley's statements that G.B. had a virus, had been seen in the emergency department, and was at a healthy weight for her age. Lavusa made no collateral contact with Children's or the pediatrician Bradley identified. Such contacts could have revealed G.B.'s weight at the zero percentile, medical staff's concerns about her size, and the absence of a one-year well-child visit.

{¶95} The Estate contends that Lavusa's failure to obtain medical records is analogous to the caseworkers' conduct in *Smathers*. *See Smathers*, 2022-Ohio-4595, at ¶ 41. There, the Supreme Court of Ohio concluded that the caseworkers' failure to promptly obtain medical records after learning of circumstances suggesting possible abuse or neglect could support a finding of recklessness. The Court reasoned that their failure to obtain the records demonstrated a "persistent opposition to a generally accepted course to follow to protect children." *Id.*

{¶96} Similarly, a jury could find that Lavusa knew, or should have known, that G.B. was significantly underweight, which, coupled with Lavusa's awareness of Bradley's ongoing food insecurity, required further investigation. Her failure to contact Children's or G.B.'s pediatrician, despite observing that G.B. appeared underweight and unwell, could demonstrate a persistent opposition to a generally accepted course of conduct to protect children and support a finding of recklessness. *See id.*

{¶97} Ultimately, reasonable minds could differ as to whether Lavusa consciously disregarded a known or obvious risk to G.B. Accordingly, whether Lavusa acted recklessly presents a question for the jury, and summary judgment based on statutory immunity was improper. We sustain the first assignment of error.

3. Stephens

{¶98} The Estate argues that Stephens acted recklessly because despite Stephens knowing G.B. had been diagnosed with failure to thrive and Bradley had admitted to restricting G.B.'s food, she approved G.B.'s discharge from Children's without a safety plan in place.

{¶99} The Estate first argues that Stephens was informed by Children's staff that G.B. was severely underweight, had been diagnosed with failure to thrive, that

there was no medical reason for G.B.'s failure to thrive, and that Bradley admitted she was restricting G.B.'s food based on an unreasonable belief that G.B. was overweight. It argues that despite this knowledge, Stephens failed to take any meaningful action to address G.B.'s failure to thrive.

{¶100} In December 2014, G.B. was severely underweight. Children's admitted G.B. for an 11-day stay and diagnosed her with failure to thrive. Social worker Litman-Padnos reported to a JFS intake worker through her call to 241-KIDS that Bradley admitted restricting G.B.'s food based on her belief that G.B. was overweight. She also explained that Children's staff could find no medical explanation for G.B.'s failure-to-thrive condition and suspected it "is related to malnutrition and restriction of food."

{¶101} Litman-Padnos's report led to JFS assigning Stephens to investigate Bradley's neglect. JFS provided Stephens with an "Intake Narrative" summarizing Litman-Padnos's report and Bradley's prior involvement with JFS. After speaking with her supervisor, Stephens called Litman-Padnos, who reiterated that G.B. was "significantly underweight" and unable to walk, and that Litman-Padnos was fearful about returning G.B. to her home because she suspected Bradley was "intentionally mistreating [G.B.]." Stephens concluded that Litman-Padnos provided no "concrete answer" about why she was afraid for G.B. to return home, despite Litman-Padnos explaining that there was no "medical reason for the failure to thrive so the only other conclusion is neglect." Litman-Padnos stressed to Stephens that G.B. could not be safely discharged without a solid safety plan.

{¶102} Stephens then visited Bradley, who admitted she believed G.B. was overweight and "maybe" had not provided proper nutrition. Children's records show staff were awaiting JFS's approval before discharge, noting they would not send G.B. home without follow up and "a good/safe plan in place." Yet Litman-Padnos

documented that Stephens felt comfortable returning G.B. home and planned only to arrange in-home services and assist Bradley in getting a psychological evaluation.

{¶103} JFS's own "Post-Death Summary" states that Stephens made no "determination about the children's safety nor any information to rule out the present danger threats identified in the hotline [241-Kids]. No action was taken." Further, the Post-Death Summary stated that there was "no documentation to support the decision to allow [G.B.] to be discharged [to] her mother."

{¶104} Here, like the defendant in *Smathers*, Stephens had actual knowledge from hospital staff that Bradley was suspected of abuse or neglect. *See Smathers*, 2022-Ohio-4595, at ¶ 40-41. Stephens knew that G.B.'s diagnosis lacked a medical explanation and knew Bradley herself admitted that she restricted G.B.'s food. Stephens discounted hospital concerns because Litman-Padnos could not identify "anything concrete," but Stephens made no effort to speak with any Children's physicians "to better understand the basis for their conclusions regarding abuse and neglect." *See id.* at ¶ 42. Further, it was only after she had approved G.B.'s discharge to Bradley that Stephens observed G.B. and was "shocked" by her appearance.

{¶105} And like in *Smathers*, medical staff were unwilling to discharge G.B. back to her mother without approval from child services, which Stephens provided. *See id.* at ¶ 40. Under these facts, a reasonable jury could find that Stephens recklessly disregarded warnings of nonorganic failure to thrive and medical concerns about neglect when she allowed G.B. to be discharged from the hospital to Bradley's care.

{¶106} We sustain the Estate's second assignment of error.

4. Setty

{¶107} The Estate argues that Setty acted recklessly by failing to assess G.B.'s safety despite knowing of her failure-to-thrive diagnosis, failing to contact medical

providers, failing to review G.B.'s case file, and failing to act on Bradley's admission that she was not taking mental-health medication.

{¶108} Setty became Bradley's ongoing caseworker in mid-January 2014 after a five-minute transfer meeting with Stephens. During that meeting, Setty learned of G.B.'s failure-to-thrive diagnosis and received Bradley's case file, which included all prior ALRs. On January 21, Stephens and Setty conducted a joint home visit, but Stephens documented nothing substantive and Setty documented nothing at all.

{¶109} Setty did not see G.B. at any point in February. She canceled one visit because of the weather and failed to locate Bradley's home on a second attempt. Setty finally saw G.B. on March 4, six weeks after she had last visited. Setty noted only that G.B. appeared sleepy and was "falling in and out of sleep." Setty admitted she did not ask about G.B.'s weight, feeding, or medical care, and she did not attempt to observe G.B.'s physical condition. She did not see G.B. again before her death. Setty unsuccessfully attempted to visit Bradley on March 26, and G.B. died three days later.

{¶110} A reasonable factfinder could conclude that Setty consciously disregarded a known risk by failing to observe G.B. for more than 40 days, document her condition, or confirm that Bradley had adequate food for her, despite knowing of G.B.'s failure-to-thrive diagnosis. *See Smathers*, 2022-Ohio-4595, at ¶ 44 (concluding that evidence of caseworkers failing to identify or address unsafe conditions in a child's room, despite having inspected it and knowing of concerns about its safety, could support a finding of recklessness).

{¶111} The evidence also raises a question of fact regarding Setty's failure to contact G.B.'s medical providers. During her March 4 visit, Bradley signed a release of information and told Setty that Help Me Grow had "closed out" its services because "everything was fine," WIC had said G.B. was "doing great," and G.B.'s pediatrician

expected her to "catch up." Setty documented her intention to follow up with these providers. She later testified that she believed she had sent requests to Help Me Grow and WIC but could not recall to whom. She acknowledged that any such requests should have been documented under JFS policy, yet the activity reports contain no such documentation. A disciplinary letter also stated that Setty had failed to follow up with Help Me Grow. Despite her stated intention to contact the providers, it appears Setty made no documented collateral contacts before G.B.'s death, several weeks later.

{¶112} A reasonable factfinder could conclude that Setty acted recklessly by failing to follow up with G.B.'s service providers despite knowing of G.B.'s failure-to-thrive diagnosis and recognizing the need for further information about her condition. *See Smathers* at ¶ 43 (concluding that a caseworker's failure to act for at least a week after being directed to offer ongoing services to a mother could support a finding of recklessness).

{¶113} The Estate further argues that Setty acted recklessly by failing to review G.B.'s medical records. Setty received Bradley's physical case file during the transfer meeting with Stephens. The file included ALRs documenting G.B.'s physical condition. Although Setty testified she may have skimmed some of the ALRs, she admitted that she did not review the medical records, including records from Children's. Given her knowledge of G.B.'s failure-to-thrive diagnosis, a reasonable factfinder could conclude that Setty's failure to review the available medical records, which contained information about G.B.'s medical condition and concerns regarding Bradley's suspected abuse or neglect, demonstrated a reckless disregard of a substantial risk of harm to G.B. *See Smathers*, 2022-Ohio-4595, at ¶ 42 (concluding that caseworkers' failure to promptly obtain medical records could demonstrate a "persistent opposition to a generally accepted course to follow to protect children").

{¶114} Viewed together and in the light most favorable to the Estate, the evidence of Setty's conduct is sufficient to permit a reasonable factfinder to conclude that she acted recklessly in the performance of her duties. We sustain the Estate's third assignment of error.

III. Conclusion

{¶115} We hold that the evidence, when viewed in the light most favorable to the Estate, creates a genuine issue of material fact as to whether the caseworkers' acts or omissions demonstrated a conscious disregard of known or obvious risks of harm to G.B. Thus, whether the caseworkers' conduct constituted recklessness is a question of fact for the jury and the trial court erroneously granted the caseworkers' motions for summary judgment.

{¶116} We sustain the Estate's assignments of error, reverse the trial court's judgment, and remand the cause for further proceedings consistent with this opinion and the law.

Judgment reversed and cause remanded.

KINSLEY, P.J., concurs.
ZAYAS, J., concurs in judgment only.