Office of Children and Family Services

Child Fatality Report

Report Identification Number: SY-19-042

Prepared by: New York State Office of Children & Family Services

Issue Date: Jan 30, 2020

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☒ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☐ The death of a child for whom child protective services has an open case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☐ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		

Case Information

Report Type: Child Deceased
Age: 17 year(s)
Jurisdiction: Madison
Gender: Male
Date of Death: 08/15/2019
Initial Date OCFS Notified: 08/15/2019

Presenting Information

An SCR report alleged on 8/15/19 at 10:00 AM, 911 was called regarding the 17-year-old subject child. First responders arrived at the home, which was in deplorable condition with garbage strewn about; however, the child had already expired. EMS performed CPR but were unsuccessful. The child's body was transported to the hospital via ambulance, where he was pronounced deceased at 10:47 AM. The hospital staff found a severe skin infection on the child, extending from his left knee down to his foot. There were multiple open wounds with decomposing dead skin that was infested with maggots. The grandmother and an unrelated household member did not seek the necessary medical care and treatment the child needed, therefore were named subjects of the report. The mother had an unknown role. A subsequent report received on the same day alleged the child went into cardiac arrest and died at the hospital from lack of medical care for an infection.

Executive Summary

This fatality report concerns the death of the 17-year-old male subject child who died on 8/15/19. Two reports were made to the SCR regarding his death. The child had a severe infection which extended from his left knee to his left foot that progressed without the intervention of medical treatment. The infection was assumed to be the result of an ingrown toenail that was not adequately treated. The child resided with his maternal grandmother, who was granted custody when the child was an infant, and an unrelated home member. The child did not have any minor siblings, and no other children resided in the home. The parents were notified of the CPS investigation.

Madison County Department of Social Services (MCDSS) coordinated with law enforcement during the investigation; law enforcement was not seeking criminal charges relating to the death. Although an autopsy was performed, the results were not yet received at the time of this writing. The coroner provided information that there were sharp force injuries to the left foot and ankle, and to the bottom of the right foot.

On the day of the death, the grandmother said the child told her something was wrong but refused to tell her specifics. She said he said everything was wrong, and then flailed his body as he fell to the floor and became unresponsive. First responders were contacted and when they arrived at the home, the deplorable condition of the home prevented EMS from immediately performing life-saving measures. The child was transported to the hospital via ambulance where he was pronounced dead at 10:47 AM. It was believed the child died as a result of sepsis.

MCDSS gathered information regarding the death from the family, law enforcement, the child's school and pediatrician, and hospital staff. Collateral contacts expressed concern for the child's poor and declining personal hygiene in the year prior to his death; however, collaterals were not aware of the severity of the child's infection.

During the investigation, the grandmother and unrelated household member were displaced after their home was condemned due to its deplorable and unsanitary condition. The record did not reflect the family was offered services.

MCDSS completed the required reports timely and accurately. The allegations of Inadequate Guardianship, Lack of Medical Care, Inadequate Food, Clothing and Shelter and DOA/Fatality were substantiated against the grandmother regarding the child. The investigation revealed the grandmother did not provide appropriate shelter for the child or seek medical attention for the child's infection which was directly related to the child's death. MCDSS unsubstantiated the allegations against the unrelated household member as she was not a person legally responsible for the child.

PIP Requirement
MCDSS will submit a PIP to the Syracuse Regional Office within 30 days of the receipt of this report. The PIP will identify action(s) the MCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, MCDSS will review the plan and revise as needed to address ongoing concerns.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** Yes

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Was the decision to close the case appropriate? Yes
Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes
Was there sufficient documentation of supervisory consultation? Yes, the case record notes a consultation took place, but no details noted.

Explain:
Casework activity was commensurate with case circumstances.

Required Actions Related to the Fatality

Are there Required Actions related to the compliance issue(s)? ☒Yes ☐No

Issue:	Failure to offer services
Summary:	Although service needs were identified including bereavement services and mental health referrals, the record did not reflect referrals for services were provided to the family.
Legal Reference:	SSL §424(10);18 NYCRR 432.3(p)
Action:	Based on the investigation and evaluation conducted, MCDSS will offer to the family such services as appropriate.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 08/15/2019 **Time of Death:** 10:47 AM

Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Madison
Was 911 or local emergency number called? Yes
Time of Call: 09:55 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? Unknown
Child's activity at time of incident:

- ☐ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☒ Unknown
- ☐ Other

Did child have supervision at time of incident leading to death? No - Not needed given developmental age or circumstances

Total number of deaths at incident event:
Children ages 0-18: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	17 Year(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	59 Year(s)
Deceased Child's Household	Mother	No Role	Female	37 Year(s)
Deceased Child's Household	Unrelated Home Member	Alleged Perpetrator	Female	61 Year(s)
Other Household 1	Father	No Role	Male	52 Year(s)

LDSS Response

On 8/15/19, MCDSS received two SCR reports regarding the death of the 17-year-old male subject child (SC) who died on the same day. MCDSS immediately contacted LE and the sources of the reports and documented a CPS history check. Within the first 24 hours of the investigation, the DA and the ME's offices were notified of the death.

The CPS history check found the SC had an infection due to an ingrown toenail in 2018. The SCR report was appropriately tracked FAR and the case was closed after the maternal grandmother (MGM) sought medical treatment for the SC.

MCDSS gathered information from hospital staff and LE. The SC did not take off his shoes or socks in some time, was unbathed and wore soiled clothing. The ER nurse said the SC's left leg had blood and fluid coming from open wounds with maggots present. There was a mark on his leg consistent with using a tourniquet and a piece of his foot was cut off. When the SC arrived at the hospital, he was cool to the touch and pale in color.

The MGM said in the weeks prior to the death, he said his foot bothered him when he walked, and she told him to cut his toenails as they bothered him in the past and he had a history of refusing to trim them. The MGM said days prior to his death, she saw the SC's leg, which appeared red, but he refused to talk about it. On the day of the fatal incident, she spoke to the SC around 9:15 AM, and he made a noise, but would not say what was wrong; eventually he stated everything was wrong, before he fell to the ground. The SC was unable to breathe, so she told the unrelated home member (OA) to call 911 while she performed CPR. The MGM said she treated the SC's ingrown toenail when CPS was involved in 2018 but did not follow through with follow-up medical care or with services offered through Community Action Partnership. The MGM said the SC did not want to utilize the services, he said his toe was fine and did not want to miss school to see a medical specialist.

Information provided by the OA corroborated what was reported by the MGM. The OA said she heard the MGM shouting at the SC upstairs, so she went up to check, and the MGM told her to call 911. The OA said she last saw the SC outside of his room three days prior to his death.

The parents were notified of the investigation and did not have additional information.

MCDSS contacted several collaterals who corroborated information provided by the MGM and OA. EMS described the home as "unlivable" and the home had garbage strewn about, making it difficult for first responders enter the home in order to get to the child and perform life-saving measures. EMS said the SC appeared to be in septic shock due to a leg infection. Additionally, his finger and toenails were unkempt.

The pediatrician saw the SC in January of 2019 and he presented with an ingrown toenail on his right foot and was prescribed an antibiotic and saltwater soaking. The SC was scheduled for follow-up visits and was referred to a specialist as the SC was seen for the infection in September 2018 and appeared to be an ongoing issue; however, the appointments were cancelled.

The SC's school said he did not attend summer school and staff were told by the MGM his toe was sore. School staff reported the SC limped on his foot during the school year, and staff told him he could die if his foot was not properly treated. In November 2018, the SC told staff he neglected his infection and only showered on Sundays. The staff provided the SC with hygiene products and clean clothes; however, he would not use them. In March 2019, the SC showered at school, but refused to take off his socks saying his foot hurt. The MGM was noncompliant with the school's recommendations.

Although MCDSS gathered information to determine the allegations and completed a thorough investigation, the record did not show services were offered in response to the fatality or regarding the MGM's and OA's home condition or mental health statuses

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Unknown
Person Declaring Official Manner and Cause of Death: Unknown

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes
Comments: The death was referred to the CFRT during the course of the investigation.

Child Fatality Report

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
052707 - Deceased Child, Male, 17 Yrs	052709 - Unrelated Home Member, Female, 61 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
052707 - Deceased Child, Male, 17 Yrs	052709 - Unrelated Home Member, Female, 61 Year(s)	DOA / Fatality	Unsubstantiated
052707 - Deceased Child, Male, 17 Yrs	052709 - Unrelated Home Member, Female, 61 Year(s)	Lack of Medical Care	Unsubstantiated
052707 - Deceased Child, Male, 17 Yrs	052709 - Unrelated Home Member, Female, 61 Year(s)	Inadequate Guardianship	Unsubstantiated
052707 - Deceased Child, Male, 17 Yrs	052708 - Grandparent, Female, 59 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
052707 - Deceased Child, Male, 17 Yrs	052708 - Grandparent, Female, 59 Year(s)	DOA / Fatality	Substantiated
052707 - Deceased Child, Male, 17 Yrs	052708 - Grandparent, Female, 59 Year(s)	Lack of Medical Care	Substantiated
052707 - Deceased Child, Male, 17 Yrs	052708 - Grandparent, Female, 59 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☐	☐	☒	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine

Were there any surviving siblings or other children in the household?	☐	☒	☐	☐

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☐	☐	☒	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☐	☐	☒	☐	☐	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☐	☐	☒	☐	☐	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☒	☐	☐	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Additional information, if necessary:
The record did not reflect services were offered to the family in response to the findings of the fatality investigation.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The record did not reflect the parents or household members were provided with service referrals in response to the fatality or service needs that were revealed during the fatality investigation.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was the child ever placed outside of the home prior to the death? Yes
Were there any siblings ever placed outside of the home prior to this child's death? N/A
Was the child acutely ill during the two weeks before death? Yes

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
11/07/2018	Deceased Child, Male, 16 Years	Mother, Female, 36 Years	Inadequate Guardianship	Far-Closed	Yes
	Deceased Child, Male, 16 Years	Mother, Female, 36 Years	Lacerations / Bruises / Welts	Far-Closed	
	Deceased Child, Male, 16 Years	Mother, Female, 36 Years	Lack of Medical Care	Far-Closed	
	Deceased Child, Male, 16 Years	Grandparent, Female, 57 Years	Inadequate Guardianship	Far-Closed	
	Deceased Child, Male, 16 Years	Grandparent, Female, 57 Years	Lacerations / Bruises / Welts	Far-Closed	
	Deceased Child, Male, 16 Years	Grandparent, Female, 57 Years	Lack of Medical Care	Far-Closed	
	Deceased Child, Male, 16 Years	Unrelated Home Member, Female, 60 Years	Inadequate Guardianship	Far-Closed	
	Deceased Child, Male, 16 Years	Unrelated Home Member, Female, 60 Years	Lacerations / Bruises / Welts	Far-Closed	
	Deceased Child, Male, 16 Years	Unrelated Home Member, Female, 60 Years	Lack of Medical Care	Far-Closed	

Report Summary:
An SCR report alleged the SC had a toe infection that started in September. He refused to remove his socks and sneakers. He was given antibiotics for his toe, but it was unknown how the infection was progressing as he refused to let anyone see it. The SC did not bathe and had a foul odor. The bathtub was used as a container for a litter of puppies. Neither the MGM or SC remembered the last time he put an antibiotic on his toe. There was blood on his toe and he did not know where the blood was from. The SC was not seen medically in weeks and the toe bled. He wore fingerless gloves and never removed them. He was scholastically challenged. The SC had anxiety, but was not diagnosed.

OCFS Review Results:
MCDSS completed an SCR history check, contacted the source of the report and appropriately tracked the case FAR. The FLAG was completed with the family timely. The 7-day Safety Assessment was not approved until 12/21/18. The record did not reflect attempts to contact the father and he was not provided with written notice of the SCR report. Referrals were made for community based mentoring services.

Are there Required Actions related to the compliance issue(s)? ☒Yes ☐No

Issue:
FAR-Timely/Adequate 7-Day Assessment
Summary:
Although accurate, the 7-day Safety Assessment was not approved until 12/21/18.
Legal Reference:
18 NYCRR 432.13 (d)(2)(i) and (ii); 18 NYCRR 432.13(d)(3)
Action:
Within seven days of receiving a report, MCDSS will conduct and document a preliminary assessment of safety to determine whether the child named in the report and any other children in the household may be in immediate danger of serious harm.

Issue:
FAR-Failure to Provide Notice of Report
Summary:
The record does not reflect the father was notified of the SCR report.
Legal Reference:
18 NYCRR 432.13 (e)(2)(i)(a)-(d)
Action:
No later than seven days after receipt of a child protective report that has been assigned to the Family Assessment Response track, the child protective service must provide written notification to every parent, guardian or other person legally responsible for the child or children named in the report

Issue:
FAR-Failure to Engage a Parent, Guardian or Other Person Legally Responsible
Summary:
The record did not reflect attempts were made to contact the father to engage him in the FAR case. The father may have had information pertinent to the reported concerns, or additional information relating to safety and risk.
Legal Reference:
18 NYCRR 432.13 (e)(2)(i)(a-d); 18 NYCRR 432.13(e)(2)(iii)
Action:
Family Assessment Response workers must work in partnership with the families participating in a Family Assessment Response.

[redacted]

CPS - Investigative History More Than Three Years Prior to the Fatality

11/20/00- 4/30/01 OA UnSub for IG and XCP regarding OC.

11/25/08- 2/23/09 MGM and MGF UnSub for IG and LMC regarding the SC.

3/30/09- 8/19/09 MGM and MGF UnSub for IF and IF/C/S regarding the SC.

5/17/13- 6/11/13 OA UnSub for IG and LMC regarding OC.

Known CPS History Outside of NYS

There was no known CPS history outside of New York State.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? ☐Yes ☒No

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No