Office of Children and Family Services

Child Fatality Report

Report Identification Number: BU-23-030

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

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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 had an open investigation or a CPS monitored services 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	DA-District Attorney	
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	SXTF-Sex Trafficking
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
Jurisdiction: Erie
Date of Death: 08/01/2023
Age: 0 day(s)
Gender: Male
Initial Date OCFS Notified: 08/27/2023

Presenting Information

On 8/27/23, an SCR report was received that alleged three weeks prior, the mother gave birth to the subject child in her pants while walking down the street. The mother heard the child cry but failed to take him for immediate medical attention. The child died while in the mother's pants of unknown causes. The mother had done several hundred dollars of cocaine that day and was impaired at the time of the child's birth. Upon returning home, the mother hid the deceased child in the garage.

Executive Summary

On 8/27/23, Erie County Department of Social Services (ECDSS) received an SCR report regarding the death of the subject child that occurred on 8/1/23. The report alleged DOA/Fatality, Lack of Medical Care, and Inadequate Guardianship against the mother regarding the subject child. No siblings or other children were living with the mother.

ECDSS gathered information from law enforcement, hospital records, and relatives regarding the circumstances of the death. It was discovered that on approximately 8/1/23, the mother was walking on the side of the road around 7:30 PM. The mother gave birth to the child and the child dropped into the pant leg of the mother's sweatpants. The mother left the child there and continued walking home. The child cried for a minute and then stopped. Once the mother arrived home she took the child out of her sweatpants and saw he was deceased. The mother hid the child's body inside a toolbox. Three weeks later, the mother was admitted to the hospital, and hospital personnel noticed she was no longer pregnant. The mother disclosed to staff that she gave birth to the child at home and he was deceased. Law enforcement located the child's remains at the mother's home.

An autopsy was conducted and the cause and manner of death were pending at the time this report was written. The medical examiner's office reported they only had bones to examine; therefore, the information they could provide would be very limited. There were no injuries to the bones. Law enforcement investigated the death and no charges were pursued at the time this report was written. It was discussed that the mother would possibly be charged with the disposal of the child's body.

ECDSS found there was a fair preponderance of evidence to substantiate the allegations of the SCR report against the mother. ECDSS determined the mother gave birth to the child and failed to obtain medical attention for him. When the child died, the mother hid the child's remains at her home until several weeks after the death. During the investigation, the mother was admitted to an inpatient facility outside of New York State. The CPS investigation was indicated and closed on 11/27/23.

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? N/A

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

Explain:
There were no other children; therefore, the completion of safety assessment tools was not required. ECDSS supported their determination with the information gathered during the investigation.

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 has detail of the consultation.

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 08/01/2023 **Time of Death:** Unknown

Time of fatal incident, if different than time of death: 07:30 PM

County where fatality incident occurred:	Erie
Was 911 or local emergency number called?	No
Did EMS respond to the scene?	No
At time of incident leading to death, had child used and/or ingested alcohol or drugs?	Unknown

Child's activity at time of incident:

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

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	0 Day(s)
Deceased Child's Household	Father	No Role	Male	45 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	29 Year(s)

LDSS Response

ECDSS had contact with the mother while she was hospitalized but gathered minimal information regarding the death of the child during their initial contact with her. ECDSS documented efforts to gather additional information, but the mother left the state for substance abuse treatment. ECDSS obtained information from law enforcement, relatives, and medical personnel regarding the mother's account of events. ECDSS notified the medical examiner’s office, district attorney’s office and Child Advocacy Center of the death.

Law enforcement reported that, while hospitalized, the mother disclosed to staff that she gave birth to the child while walking on the side of the road. The child began to cry and then stopped crying. The mother initially said she buried the child in a cemetery; however, when law enforcement was unable to locate the burial site, the mother admitted the child’s body was at her home. Law enforcement went to the mother's home and located the decomposed child wrapped in towels, in a backpack, and placed in a toolbox in the backyard. Law enforcement spoke to the alleged father, who reported he did not know of the mother's actions, and the mother told him that CPS removed the child from her care.

Hospital records gathered by ECDSS showed that on 8/27/23 the mother was admitted to the hospital. The hospital was aware the mother was recently pregnant, as she had an OBGYN appointment on 7/31/23 and was given a gestational age of 34 weeks and 2 days. Hospital staff inquired about the mother no longer being pregnant. The mother reported that approximately two weeks prior, she used a large quantity of cocaine and began walking back to her home. While she was walking home, her water broke, and she delivered the child into the leg of her sweatpants. The mother did not have a phone or a way to contact help. The mother did not want to expose herself on the side of the road so continued walking with the child inside of her pants. The mother arrived home 10 minutes later and the child was deceased. The mother reported she did not contact law enforcement or emergency medical services because she did not want to get into trouble for the death of the child and her cocaine use. The mother denied telling the alleged father about the death of the child.

A relative reported that she and the alleged father could tell the mother was no longer pregnant a few weeks prior, and the mother told them the child was with the aunt. The relative did not believe the alleged father was aware of how the mother disposed of the child.

At the time the CPS investigation was closed, the mother was admitted to inpatient substance abuse treatment for concerns of substance abuse and mental health. ECDSS attempted to interview the alleged father though he did not make himself available to be interviewed.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

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

Was the fatality referred to an OCFS approved Child Fatality Review Team?Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
065820 - Deceased Child, Male, 0 Day(s)	065821 - Mother, Female, 29 Year(s)	Lack of Medical Care	Substantiated
065820 - Deceased Child, Male, 0 Day(s)	065821 - Mother, Female, 29 Year(s)	DOA / Fatality	Substantiated
065820 - Deceased Child, Male, 0 Day(s)	065821 - Mother, Female, 29 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?	☒	☐	☐	☐

Additional information:

Efforts to interview the alleged father were unsuccessful.

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 mother was hospitalized at the time of the SCR report. She remained at the hospital for inpatient mental health services. The mother was then admitted to inpatient substance abuse services in another state. All services were coordinated by the hospital.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother was provided services through the hospital.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes

Was the child acutely ill during the two weeks before death? No

Infants Under One Year Old

During pregnancy, mother:

- ☐ Had medical complications / infections
- ☐ Had heavy alcohol use
- ☐ Misused over-the-counter or prescription drugs
- ☐ Smoked tobacco
- ☐ Experienced domestic violence
- ☒ Used illicit drugs
- ☐ Had a positive toxicology at the time of delivery
- ☐ Used prescription drugs
- ☐ Used marijuana
- ☐ Was not noted in the case record to have any of the issues listed

Infant was born:

- ☐ With a positive toxicology
- ☐ With fetal alcohol effects or syndrome
- ☐ Exhibiting withdrawal symptoms
- ☒ With none of the issues listed noted in case record

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
08/17/2023	Deceased Child, Male, 0 Days	Mother, Female, 29 Years	Inadequate Guardianship	Substantiated	No

Report Summary:
An SCR report alleged that the mother gave birth to the subject child 3 weeks before the report date. The mother had a history of drug abuse and engaging in prostitution. As a result, the mother had two children removed from her care, and her parental rights were terminated. It was unknown if the mother was still abusing drugs and prostituting.

Report Determination: Indicated | **Date of Determination:** 09/13/2023

Basis for Determination:
ECDSS substantiated the allegations against the mother. It was determined that the mother gave birth to the subject child while walking down the street. The mother provided conflicting information regarding whether the child was alive or dead at the time of his birth. The mother put the child in a book bag and left him in the garage of the mother's home. The mother then put the child in a toolbox in the backyard. The mother did not contact 911 or reach out to medical personnel to examine the child or inform anyone she had given birth. The mother overdosed several weeks later and was hospitalized, which was when she informed staff about the birth of the child.

OCFS Review Results:
Upon receipt of the SCR report, ECDSS contacted hospital staff who reported that the mother had not given birth to the child at their facility, but an SCR report would be made once the mother did give birth. ECDSS made efforts to locate the mother via home visits, phone calls, and collateral contacts, all of which were unsuccessful. A fatality report was registered regarding the death on 8/27/23 after the mother was hospitalized and reported the birth and death of the child.

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

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

There was no CPS investigative history more than three years prior to the fatality.

Known CPS History Outside of NYS

There was no known CPS History outside of NYS.

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.

Additional Local District Comments

We at the Erie County Department of Social Services appreciate the opportunity given us to review the draft report in advance. We find that the facts, as written, describe the unfortunate events and the actions taken in response. We are pleased that OCFS found that the fatality investigation was conducted appropriately and that there are no required actions related to the fatality or to the CPS investigation conducted during the three years preceding the fatality.

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