Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-19-055

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

Issue Date: Feb 21, 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	ASTO-Allowing Sex Abuse to Occur	

Case Information

Report Type: Child Deceased
Age: 0 day(s)
Jurisdiction: Orange
Gender: Female
Date of Death: 11/12/2019
Initial Date OCFS Notified: 11/13/2019

Presenting Information

An SCR report was received with concerns on 11/12/19, the mother gave birth to a child outdoors, then left the newborn child on a large rock in a ditch in freezing temperatures. The report alleged the child experienced hypothermia and died while lying on the rock. A passerby walking the same path found the deceased child hours later, and reported it to the police. The role of the biological father was unknown.

Executive Summary

This fatality report concerns the death of a newborn female subject child (SC) that occurred on 11/12/19. A report was made to the SCR on 11/13/19 with allegations of Inadequate Guardianship and DOA/Fatality against the child's mother (SM). Orange County Department of Social Services (OCDSS) received the report and investigated the child's death. An autopsy was completed; however, the official cause and manner of death were not yet available at the time of this writing. The Medical Examiner informed law enforcement the manner would most likely be ruled homicide.

The mother and father (BF) resided together, and there were no surviving siblings or other children in their home. The investigation revealed on the night of 11/12/19, the mother prematurely and unexpectedly gave birth to the child outside in a vacant lot near her residence. The mother reported to law enforcement and OCDSS that she was unaware she was pregnant, and the child was approximately 28-weeks-gestation. Upon delivering the child, the mother severed the umbilical cord with her hands, and then left the child on the ground, unattended, in below freezing temperatures. There was conflicting information gathered concerning whether the child was breathing when the mother left her on the ground, or if she was already deceased; however, examination of the child's body and evidence gathered by law enforcement confirmed the child was alive at the time of her birth. After deserting the child, the mother walked back to her home; she did not contact emergency services, nor did she inform anyone she had just given birth. Approximately two hours after the incident, a child from the neighborhood was walking through the area and stepped on the deceased infant. That child's mother contacted authorities, and shortly thereafter, the mother informed law enforcement of what occurred. Numerous family members were interviewed, and all denied knowing the mother had been pregnant until the police became involved.

From the time the investigation began to the time of its closure, OCDSS spoke with several collateral sources and offered the family appropriate services in response to the child's death. At the time of this writing, no formal criminal charges had been filed against the mother. OCDSS substantiated the allegations and closed the case.

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:
OCDSS gathered sufficient information to appropriately determine the allegations. There were no SS.

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:
The case record reflected supervisory consultations throughout the investigation. The level of casework activity was commensurate with the 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: 11/12/2019 **Time of Death:** Unknown

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

County where fatality incident occurred: Orange
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 alcohol or drugs? No
Child's activity at time of incident:

☐ Sleeping ☐ Working ☐ Driving / Vehicle occupant
☐ Playing ☐ Eating ☐ Unknown
☒ Other: SM had just given birth.

Did child have supervision at time of incident leading to death? No - but needed
At time of incident supervisor was:

☒ Drug Impaired ☐ Absent
☐ Alcohol Impaired ☐ Asleep
☐ Distracted ☐ Impaired by illness

☐ Impaired by disability ☐ 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	Female	0 Day(s)
Deceased Child's Household	Father	No Role	Male	22 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	22 Year(s)

LDSS Response

On 11/13/19, OCDSS received the SCR report regarding the death of SC, which occurred on 11/12/19. OCDSS initiated their investigation within 24 hours and coordinated their efforts with their multidisciplinary team. OCDSS discovered SC was the only child residing in the household; however, there were related CHN that lived in the same two-family home and were present the night of the incident. OCDSS worked promptly to assess their safety and found no concerns.

On 11/13/19, OCDSS received information from LE that the case was being handled as a homicide. On this same date, OCDSS met with LE at the police barracks to begin gathering information. LE explained their interviews with SM indicated SM was not aware she was pregnant when she gave birth in a vacant lot near the case address. LE stated SM admitted to LE that SC was alive and breathing when SM severed the umbilical cord with her hands and then left the child outside in the vacant lot. LE reported the ME had made preliminary statements that SC was a live birth. LE also reported a neighbor's home security camera captured SM giving birth and leaving SC unattended.

After meeting with LE, OCDSS completed a home visit to the case address and met with BF as well as other family members. These family members included paternal grandparents and paternal great grandparents. All individuals reported they were unaware SM was pregnant, and unaware she had given birth until after LE became involved. OCDSS did not observe any infant-related items in the home.

On 11/15/19, OCDSS again visited the case address and interviewed SM. SM explained on 11/12/19, she woke up and felt cramping in her stomach throughout the day and assumed it was her menstrual cycle. SM reported that night, she and BF got into an argument surrounding an unpaid debt owed to an individual who supplied them with drugs. SM said this argument is what prompted her to leave the home on foot, and as she neared the end of the block, the cramps became severe and caused SM to "hunch over." SM reported to OCDSS she then "felt the baby being born" and that SC "slid down" the leg of the pants she was wearing. SM stated SC was crying and she "tried to save it;" however, could not articulate why she felt SC needed saving at that time. SM reported she cut the umbilical cord with her fingers and held SC until SC passed away. SM stated she then left SC on the sidewalk because she did not want to "walk in the house with a dead baby." SM explained upon returning home, she took a bath for approximately 30 minutes, and did not tell anyone that she had just given birth until after LE became involved later that night.

On this same date, OCDSS also spoke with BF. BF reiterated he and SM were arguing over SM not paying their drug dealer, and recalled SM left the home due to being upset. BF stated he was unsure how long SM was gone, but when she returned, she went straight to the bathroom and refused to come out. BF explained eventually SM did exit the bathroom and the two reconciled. BF then went into the bedroom to play video games. BF stated a short time later, the family

noticed LE was "all over the block," and that is when BM confessed she had just given birth and left SC outside. BF said he told SM she had to go and tell the police what happened, and she did so. BF again stated he was not aware SM had been pregnant.

Throughout the investigation, OCDSS spoke with numerous collateral sources, including the ME, first responders and family members. The criminal investigation remained ongoing at the time of this writing; however, SM had yet to be charged regarding SC's death. OCDSS gathered evidence to substantiate the allegations in the report, and therefore indicated and closed the case.

Official Manner and Cause of Death

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

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes
Comments: This fatality investigation was conducted by the Orange County Multidisciplinary Team.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes
Comments: This fatality was reviewed by the Orange County Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
053225 - Deceased Child, Female, 0 Days	053226 - Mother, Female, 22 Year(s)	DOA / Fatality	Substantiated
053225 - Deceased Child, Female, 0 Days	053226 - Mother, Female, 22 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:
OCDSS interviewed the family and appropriate collateral sources. Progress notes and other documentation were completed and entered timely.

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:
OCDSS provided the parents with information for services to address their ongoing needs.

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? N/A
Explain:
There were no SS or other CHN in the home.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Appropriate services were offered to the parents regarding the loss of SC, as well as to address other needs.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
Was the child ever placed outside of the home prior to the death? No
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? No

Infants Under One Year Old

During pregnancy, mother:
☐ Had medical complications / infections
☐ Misused over-the-counter or prescription drugs
☐ Experienced domestic violence
☐ Was not noted in the case record to have any of the issues listed
☐ Had heavy alcohol use
☐ Smoked tobacco
☒ Used illicit drugs

Infant was born:
☐ Drug exposed
☒ With neither of the issues listed noted in case record
☐ With fetal alcohol effects or syndrome

CPS - Investigative History Three Years Prior to the Fatality

There is no CPS investigative history in NYS within three years prior to the fatality.

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

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

Known CPS History Outside of NYS

There was no known CPS history outside of NYS. w

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