



Report Identification Number: NY-21-113

Prepared by: New York City Regional Office

Issue Date: Apr 12, 2022

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: 2 day(s)

Jurisdiction: Bronx
Gender: Male

Date of Death: 10/25/2021
Initial Date OCFS Notified: 10/25/2021

Presenting Information

The SCR report alleged on 10/24/21, the mother gave birth to a male child at home. When the child started to cry, the mother wrapped him in a blanket to hide him from the maternal grandmother and step-father. The mother went downstairs to get something to eat. When she returned, the child was not moving; she panicked and placed the child in a blue pillowcase and dropped him out of the window. The child was eventually found by law enforcement and pronounced dead on 10/25/21. The cause of death was unknown.

Executive Summary

This fatality report concerns the death of a two-day-old male subject child who died on 10/25/21. As of the writing of this report, NYCRO had not received a copy of the final autopsy report from the Medical Examiner.

At the time of the incident, the mother resided in the home with her mother and step-father. The deceased child was the only child for the parents and there were no other children in the home.

ACS' investigation revealed on 10/24/21, the mother was escorted to the emergency room by the maternal grandmother, due to an abdominal laceration. The laceration was not consistent with the account provided by the mother and after further tests, the mother disclosed she had given birth. After giving multiple inconsistent accounts, law enforcement was contacted and an investigation was initiated.

ACS later contacted law enforcement and learned that the newborn was found on the premises of the case address. Law enforcement reported that on 10/23/21, the mother gave birth in the bedroom of her home and placed the newborn in a pillowcase and threw him out of her bedroom window. ACS contacted the District Attorney who confirmed criminal charges would be sought against the mother for the death of the newborn.

The Medical Examiner declined to give a preliminary finding due to the nature of the case; the final report was pending as of 3/30/22.

The maternal grandmother declined ACS' request for information from the mother's pediatrician. ACS initially interviewed the mother; however, was unable to re-interview her because she had obtained legal counsel. The case was closed and referred to community based services.

ACS interviewed collateral contacts and they reported the mother showed no signs of pregnancy and there were no noted concerns regarding the mother's behavior.

On 12/24/21, ACS substantiated the report citing credible evidence existed to support the substantiation of the allegations.

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 was credible evidence to substantiate the allegations of the report.

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 level of casework activity, which included contact with the family and others from the receipt of the report through case conclusion, 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: 10/25/2021

Time of Death: Unknown

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

County where fatality incident occurred: Bronx

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? N/A

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? Yes



At time of incident was supervisor impaired? Not impaired.

At time of incident supervisor was:

- Distracted
- Absent
- Asleep
- Other: **Was in the home.**

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	2 Day(s)
Deceased Child's Household	Grandparent	No Role	Female	42 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	17 Year(s)
Deceased Child's Household	Stepfather	No Role	Male	41 Year(s)
Other Household 1	Father	No Role	Male	17 Year(s)

LDSS Response

Within the first 24 hours of the receipt of the fatality report from the SCR, ACS completed a CPS history check, contacted the source of the report, notified the district attorney and medical examiner's offices of the death, and coordinated the investigation with law enforcement who reported they had found the newborn; the final autopsy report was pending.

On 10/25/21, the mother told hospital staff about the child's birth; however, she had no explanation for the lacerations. The staff contacted LE about the missing newborn. During the investigation, the building staff reportedly had moved a blue bag from the area; LE found the bag and discovered the newborn. The Medical Examiner Investigator was contacted, and the newborn was pronounced dead on the same day.

ACS contacted the Medical Examiner who confirmed a newborn male with umbilical cord and placenta attached was found on the premises at the case address and he was alive when thrown out the window.

ACS interviewed the mother at the hospital and learned that she requested her pediatrician to not disclose the pregnancy to the maternal grandmother. The mother stated she ignored calls and referrals from the pediatrician, including the message that informed her of the soon to be delivery date. The mother stated she was afraid to tell her parents of the pregnancy as she did not want to disappoint them.

According to the mother, on 10/23/21, between 3:00 and 4:00PM, she began labor. During that evening, the maternal grandmother and step-father were in the living room watching television; the grandmother texted her to ask if she was okay. She responded yes that she was menstruating. Between 7:00PM and 8:00PM, she felt the urge to push. She set up a bunch of bedsheets on the floor and positioned herself at the edge of her bed and pushed the baby out. She placed a metal hair clip on the umbilical cord and cut it. Shortly after, a sac fell out and she was scared as she did not know it was the placenta. She wrapped the newborn, umbilical cord, and placenta in a blanket and placed him on her bed. She reported the newborn made winning noises and clenched his fist. She explained that the television in the living was loud. The maternal grandmother knocked on the bedroom door, she opened the door and observed bloody sheets on the floor. However, the door was ajar to an angle that she could not see the newborn. The maternal grandmother gave her clean sheets and a garbage bag and told her to clean up.



The maternal grandmother texted her to come to the kitchen for dinner and at 9:30 PM she ate a few bites, told her parents she was not feeling well and returned to her room. Upon her return, she observed the newborn's chest not moving and no air expelled from his nostrils. She panicked, placed him in a pillowcase and threw him out the bedroom window. The following morning, she left home to go to the ER but did not see the pillowcase because she walked the opposite direction.

ACS noted the mother appeared sad and teary-eyed. She denied past thoughts of suicide or mental health conditions, domestic violence, or drug/alcohol misuse.

ACS interviewed the biological father who reportedly told the mother he was not ready to be a father and that she should seek medical attention.

ACS interviewed the maternal grandmother and step-father who denied knowledge or signs of pregnancy. Their legal counsel advised them not to discuss the incident. The parents declined permission for ACS to retrieve medical information.

The school staff reported the mother progressed academically and was a delightful student.

On 12/24/21, ACS substantiated the DOA/Fatality and IG of the newborn by the mother citing their investigation revealed the mother failed to meet a minimum standard of care for the newborn. The mother reported approximately three hours afterbirth, she observed the newborn stopped breathing, but failed to seek medical attention for herself and the newborn.

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? No

Comments: There is no OCFS approved Child Fatality Review Team in the NYC Region

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
060069 - Deceased Child, Male, 2 Days	060070 - Mother, Female, 17 Year(s)	DOA / Fatality	Substantiated
060069 - Deceased Child, Male, 2 Days	060070 - Mother, Female, 17 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>



When appropriate, children were interviewed?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Alleged subject(s) interviewed face-to-face?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All 'other persons named' interviewed face-to-face?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contact with source?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All appropriate Collaterals contacted?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was a death-scene investigation performed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coordination of investigation with law enforcement?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there timely entry of progress notes and other required documentation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Economic support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Funeral arrangements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Housing assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Mental health services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Foster care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Legal services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Family planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Homemaking Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>



Child Fatality Report

Parenting Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Domestic Violence Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Early Intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Alcohol/Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Child Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Intensive case management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Family or others as safety resources	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Additional information, if necessary:
 The SM disposed of her newborn son. It is unknown whether the family held a funeral.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes

Explain:
 The SM engaged in mental health services at a community hospital.

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? No
- 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
- Was not noted in the case record to have any of the issues listed

Infant was born:

- Drug exposed With fetal alcohol effects or syndrome
- With neither of the issues listed noted in case record

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 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.

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