



Report Identification Number: SV-18-052

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

Issue Date: Dec 05, 2018

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 Still Born
Age: Unknown

Jurisdiction: Rockland
Gender: Female

Date of Death: Unknown
Initial Date OCFS Notified: 08/29/2018

Presenting Information

An SCR report alleged a woman gave birth to an unnamed female child on 7/20/2018, while on the toilet. The child's mother and father then left the newborn child in the toilet for an unknown period of time. The parents called EMS during that time. The newborn had a slow heartbeat and slow breathing when removed from the toilet by medical personnel. The child died shortly thereafter, due to being left in the toilet.

Executive Summary

On 8/29/2018, Rockland County Department of Social Services (RCDSS) received an SCR report alleging a child died on 7/20/2018. The report alleged the child's mother gave birth to her on the toilet, then left her there, which resulted in the child's death. The report further alleged the father was involved in such acts of omission as well.

The investigation revealed that the mother was unaware she was pregnant, and suffered cramps on 7/19/2018. The next day while at home, her cramps became severe and she asked her younger sister to call 911. The mother went into the bathroom, and by the time EMS arrived, the mother had delivered a fetus. The fetus was retrieved from the toilet. EMS detected a heartbeat, but due to the child's gestational age, which was estimated at 22-23 weeks, the child could not be intubated. Medics performed CPR in route to the hospital, which was difficult due to the child's size, and the child could not be revived. A neonatologist at the hospital also attempted to revive her, but was unsuccessful. The Medical Examiner explained there had been no chance for the fetus to survive outside the womb at that gestational age.

After speaking with the family, hospital staff, and the Medical Examiner, it was learned the circumstance was classified as a "fetal demise" rather than a live birth and death. The Medical Examiner informed this was not considered a viable birth, and refused jurisdiction over the case; thus, no autopsy was completed.

Law enforcement became involved due to the nature of the allegations, and investigated alongside RCDSS. Police relayed they found no reason for any criminal charges.

RCDSS assessed the safety of the one child in the home – the mother's 14-year-old sister – where she resided with her father. No safety concerns were revealed.

The mother was unsure who the biological father of the child was. There was no male present at the scene aside from the mother's own father, who arrived home in response to the emergency before the ambulance left. He may have been misrepresented as the child's father in the SCR report and EMS records. EMS staff noted with certainty there had not been a biological father present at the home. Law enforcement also had no record of a biological father being present at the scene upon their response to the home. As a result, allegations against the unknown father were rightfully unsubstantiated.

RCDSS discussed services, and learned the mother was participating in therapy on her own accord. No other service needs were identified. After conducting a thorough investigation, RCDSS made the appropriate determination to unfound the report, 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:**
 - **Approved Initial Safety Assessment?** Yes
 - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** 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

Explain:

The determination was appropriate and well-supported in documentation after a sufficient amount of information as gathered. The safety assessments and recorded decisions were appropriate.

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, and the decision to close the case was appropriate. There was extensive documentation about detailed consultation with supervisors and agency staff.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities**Household Composition at time of Fatality**

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Aunt/Uncle	No Role	Female	14 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	



Deceased Child's Household	Grandparent	No Role	Male	58 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	23 Year(s)
Other Household 1	Father	Alleged Perpetrator	Male	23 Year(s)

LDSS Response

RCDSS promptly initiated an investigation upon receipt of the SCR report. RCDSS spoke with the source, who was questioning the circumstances of the incident weeks later after the remains had been left unclaimed at the hospital. The Medical Examiner was spoken with, and clarified their office did not conduct an autopsy nor certify the death. This was because of the age of the fetus, and in the Medical Examiner's opinion, it was a miscarriage, not a birth and death. It was further stated she did not think there was any chance the fetus would have survived; thus, it was concluded there were no actions or inactions on the part of the mother that contributed to the outcome.

The mother was spoken with and shared she practiced birth control and did not think she could get pregnant, and was not aware she had become pregnant. The mother was uncertain who the father could have been. She explained she had severe cramping on 7/19/2018 which worsened the following day. She asked her sister to call 911, and while she was attempting to use the toilet, she delivered the fetus. EMS arrived and cut the umbilical cord, and EMS and police tried to revive the child. The mother appeared distraught about the events, and when asked, she stated she was already in counseling.

At the time of the incident, police responded to the home with EMS. RCDSS spoke with the detective who had responded, and he clarified law enforcement had previously discussed the case with the Medical Examiner; since it was agreed it was a non-viable birth, there had been no need to alert the Statewide Central Registry for Abuse and Maltreatment.

The mother's 14-year-old sister was interviewed, and it was apparent she had no knowledge the mother had miscarried on the date in question. RCDSS respected the mother's wishes not to share that information with her sister. RCDSS found no safety concerns for the mother's sister, or for her care which was provided by their father. RCDSS discussed services with the family, and it was shared they did not feel the need for any. They identified having resources if the need arose.

RCDSS thoroughly examined all allegations, including the alleged role of an unknown biological father. There was evidence of extensive case consultation among agency staff, medical providers, and law enforcement. RCDSS obtained a plethora of medical documentation from the hospital, Medical Examiner, and first responders. The documentation supported RCDSS' final determination. All casework activity was completed timely, accurately, and commensurate with case circumstances.

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? No

Comments: There is no OCFS approved Child Fatality Review Team in Rockland County.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
048423 - Deceased Child, Female,	048425 - Father, Male, 23 Year(s)	Inadequate Guardianship	Unsubstantiated
048423 - Deceased Child, Female,	048424 - Mother, Female, 23 Year(s)	DOA / Fatality	Unsubstantiated
048423 - Deceased Child, Female,	048425 - Father, Male, 23 Year(s)	DOA / Fatality	Unsubstantiated



048423 - Deceased Child, Female, | 048424 - Mother, Female, 23 Year(s) | Inadequate Guardianship | Unsubstantiated

CPS Fatality Casework/Investigative Activities

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

Additional information:

RCDSS contacted an array of collaterals, including those regarding the other child in the home.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At 7 days?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At 30 days?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are there any safety issues that need to be referred back to the local district?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>



Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there an adequate assessment of the family's need for services?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were appropriate/needed services offered in this case	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Explain as necessary: No child needed to be removed.				

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

Additional information, if necessary:

The mother was receiving mental health services prior to the miscarriage; her services continued thereafter, to include counseling surrounding her grief.

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? No

Explain:

There were no siblings. There were no needs identified for the other child in the household (the mother's sister).

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

Explain:

The mother was already engaged in mental health services prior to the miscarriage. She continued to engage in services, which included addressing her grief surrounding the circumstances.

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 is no CPS history for anyone in the family composition.

Known CPS History Outside of NYS

There is 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