Child Fatality Report

Report Identification Number: AL-25-016

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

Issue Date: Sep 23, 2025

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 Grandmother	MGF-Maternal Grandfather	FF-Foster Father
PGM-Paternal Grandmother	PGF-Paternal Grandfather	DCP-Day Care Provider
MGGM-Maternal Great Grandmother	MGGF-Maternal Great Grandfather	PGGF-Paternal Great Grandfather
PGGM-Paternal Great Grandmother	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-Caseworker	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
Age: 4 month(s)
Jurisdiction: Otsego
Gender: Male
Date of Death: 04/21/2025
Initial Date OCFS Notified: 04/21/2025

Presenting Information

On 04/17/2025, OCDSS received an SCR report that alleged on 04/16/25, the mother, found her 4-month-old child in his bassinet face down. The subject child's face was blue, and he was in cardiac arrest. The mother failed to call 911 and called the subject child's father, who is a resident physician at the hospital located across the street from the home. On 04/21/2025, the subject child died while at the hospital and a 7065-agency reporting form was issued resulting in a subsequent report to the SCR. The subsequent report alleged that on 04/16/2025, the mother placed the subject child down for a nap in a bassinette and went to sleep, when she woke, she discovered the subject child face down in the bassinet and unresponsive. The mother performed CPR and reached out to unknown relatives to transport the child to the hospital were the child regained a pulse and was transferred to another hospital. On 04/21/2025, the child was pronounced deceased due to the events on 04/16/2025.

Executive Summary

This report concerns the death of the 4-month-old male subject child. On 04/17/2025, Otsego County Department of Social Services (OCDSS) received an SCR report, with allegations of Inadequate Guardianship and Lack of Medical Care against the mother and father regarding the subject child. On 04/21/2025, OCDSS received a subsequent report with allegations of DOA/Fatality and Inadequate Guardianship against the mother regarding the subject child. On the same date, a 7065-agency reporting form was filed regarding the death. OCDSS later added the allegations of DOA/Fatality and Inadequate Guardianship against the father regarding the subject child. At the time of the child's death, he resided with his mother, father, and 5-year-old sibling. The safety of the surviving sibling was assessed within 24-hours, and she was deemed safe while in the parents' care.

OCDSS coordinated investigation efforts with law enforcement. Law enforcement and the department conducted interviews with the mother and father as well as hospital staff. It was learned through these interviews that the mother was the sole caretaker to the child on the day of the fatal incident. The mother placed the child on her adult bed to breastfeed the child. Once the child was done eating the child fell asleep on the bed. The mother then left the room to do errands and when she returned to the room the child was face down on a toddler bed positioned next to the adult bed. The child was unresponsive and blue in color. A reenactment of the events leading up to the fatal incident was conducted by law enforcement and with the cooperation of the parents. Law enforcement and the district attorney's office did not file any charges against the parents regarding the fatal incident. The incident was determined to be accidental, and there was no evidence of neglect or trauma to the subject child. Law enforcement had closed their investigation with no concerns for the family.

The Coroner's Office provided a death certificate for the child which identified his immediate cause of death to be anoxic encephalopathy due to resuscitation following prolonged cardiac arrest likely due to positional asphyxiation. The coroner noted that the external and radiologic postmortem examination revealed no evidence of trauma or congenital abnormality. A full autopsy was not performed due to the family's religious beliefs.

This investigation was indicated and closed on 06/04/2025. Referrals for grief services and counseling were provided to the family. OCDSS appropriately substantiated the allegations of DOA/Fatality and Inadequate Guardianship against the mother as well as the allegation of Inadequate Guardianship against the SF. OCDSS reported that the parents failed to

exercise a minimum degree of care by leaving the child in a sleeping area in which the physical condition of the area was unsafe. OCDSS inappropriately substantiated the allegations of DOA/Fatality against the SF as the SF was not present when the child was placed to sleep on the bed, leading to the fatal incident. OCDSS appropriately unsubstantiated the allegations of Lack of Medical Care as the parents acted appropriately in seeking medical care for the child and surviving sibling. The parents reported that bed sharing was a cultural belief; however, at the close of the investigation showed an understanding of the dangers of bed sharing.

PIP Requirement

This review resulted in a citation related to casework practice. In response, OCDSS will submit a PIP to the Albany Regional Office within 30 days of receipt of this report. The PIP will identify what action(s) the OCDSS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, OCDSS will review the plan(s) and revise as needed.

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?** No

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 not Commensurate with the case circumstances.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	OCDSS determined the allegation of DOA/Fatality against the father as substantiated; however, the record did not reflect that the father contributed to or caused the death of the child.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	OCDSS will refer to the CPS Program Manual when determining the appropriateness of allegations and will consult with the Albany Regional Office if further guidance is needed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 04/21/2025 **Time of Death:** 10:44 PM

Date of fatal incident, if different than date of death: 04/17/2025
Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Otsego
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? No
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	4 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	28 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	28 Year(s)
Deceased Child's Household	Sibling	No Role	Female	5 Year(s)

LDSS Response

On 04/21/2025, OCDSS received an SCR report regarding the death of the 4-month-old SC. OCDSS initiated their investigation within 24 hours, completed a CPS history check which revealed one prior historical case, and coordinated their efforts with law enforcement. OCDSS completed a 24-hour-safety assessment, contacted the ME, and DA.

OCDSS conducted an interview with the parents directly following the fatal incident. The SM gave an account of the events that occurred on 04/16/2025. The SM reported that she had been breastfeeding the SC on her bed when the SC fell asleep. The SM left the SC on the bed, on his back, towards the side of the bed. There was a toddler bed located directly next to the adult bed, which had blankets and other objects on it. The SM stated that she did her hair, checked on the SC, who was sleeping in the same position, and then went downstairs to do 28-minute workout. The SM stated that when she went back upstairs the SC was face down on the toddler bed with his legs on the rails. The SM reported that the SC's body was blue, and limp. The SM began performing CPR while calling the SF. The SF then ran home from the hospital, where he was working. It took the SF 3-4 minutes to arrive at the home, time stamps on the SM's phone confirmed this. While the SM was waiting for the SF to arrive, she continued compressions and breaths and reported that the SC's body became pinker. When the SF arrived at the home he and the SM ran to a neighbor's house, who transported them to the hospital emergency room, where the SC continued to receive compressions. The SC regained a pulse and was transferred to another hospital for further care. While at the hospital, tests were performed that concluded the SC had an anoxic brain injury (brain death). On 04/21/2025, at 10:44pm, lifesaving measures were withdrawn and the SC passed away. The SF confirmed the SM's recall of events. The SF and SS were not home at the time of the fatal incident. The parents and collateral contacts all denied any concerns for drug or alcohol misuse. The SS was interviewed and assessed as safe in the parents' care.

Throughout the course of the investigation, the sheriff's department, the NYS Troopers, medical and community resource collaterals where contacted. During interviews with outside service providers and the child's primary care provider, it was learned that the parents were educated on the importance of safe sleep. During interviews with the parents, and the SS, it was determined that the family regularly practiced unsafe sleep, including bed sharing. The family reported that bed sharing was a part of their cultural beliefs, and the family practiced bed sharing despite being aware of the dangers.

OCDSS completed all safety and risk assessments and closed their investigation timely. The allegation of DOA/Fatality against the father was substantiated inaccurately; however, the remaining allegation determinations were accurate with documentation regarding a fair preponderance of evidence to support their findings. OCDSS's documentation was timely, safe sleep procedures were discussed with the family and the importance of following safe sleep procedures in the future.

Official Manner and Cause of Death

Official Manner: Accident

Primary Cause of Death: From an injury - external cause

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
071952 - Deceased Child, Male, 4 Month(s)	071954 - Mother, Female, 28 Year(s)	DOA / Fatality	Substantiated
071952 - Deceased Child, Male, 4 Month(s)	071954 - Mother, Female, 28 Year(s)	Inadequate Guardianship	Substantiated
071952 - Deceased Child, Male, 4 Month(s)	071954 - Mother, Female, 28 Year(s)	Lack of Medical Care	Unsubstantiated
071952 - Deceased Child, Male, 4 Month(s)	071955 - Father, Male, 28 Year(s)	DOA / Fatality	Substantiated
071952 - Deceased Child, Male, 4 Month(s)	071955 - Father, Male, 28 Year(s)	Inadequate Guardianship	Substantiated
071952 - Deceased Child, Male, 4 Month(s)	071955 - Father, Male, 28 Year(s)	Lack of Medical Care	Unsubstantiated

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?	☒	☐	☐	☐

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?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

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?	☐	☐	☒	☐

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☒	☐	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
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?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐

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?	☐	☒	☐	☐
Were there surviving children in the household that were removed as a result of information uncovered during the fatality investigation?	☐	☒	☐	☐

Legal Activity Related to the Fatality

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

Services at the Time of and/or in Response to the Fatality

Services	Received	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A
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	☐	☐	☐	☐	☐	☒
Preventive Services	☐	☐	☐	☐	☐	☒
Other	☐	☐	☐	☐	☐	☒

Were services offered to and/or received by siblings or other children in the household at the time of and/or in response to the fatality? Yes
Explain:
Bereavement services were offered to the family for the child; however, it was unknown if these services were utilized.

Were services offered to and/or received by parent(s) and other care givers at the time of and/or in response to the fatality? Yes
Explain:

Bereavement and burial assistance were offered to the family. The funeral home covered all costs of the funeral. It was unknown if the family followed through on any bereavement or burial assistance.

History Prior to the Fatality

Child Information

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

Infant was born:

- ☐ With a positive toxicology
- ☐ Exhibiting withdrawal symptoms
- ☐ With fetal alcohol effects or syndrome
- ☒ 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)
08/03/2023	Sibling, Female, 3 Years	Mother, Female, 27 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Female, 3 Years	Mother, Female, 27 Years	Lack of Supervision	Unsubstantiated	

Report Summary:
An SCR report was received on 08/03/2023, with allegations of IG and LS against the SF and SM regarding the then 3-year-old SS. It was reported that the SS was found in the hospital parking lot with no adult present.

Report Determination: Unfounded

Date of Determination: 01/02/2024

Basis for Determination:
The allegations were unsubstantiated. The Investigation Conclusion Narrative reported that the SS was at a neighbor's playing with their child when the SS wanted to return home which was directly across from the neighbor. The neighbor did not watch the SS return home and the SS walked across the street where she was found in the hospital parking lot. The parents planned to have better communication with the neighbor in the future and not let the SS walk without

supervision back and forth between apartments. The parents believed the SS was still at the neighbors and the neighbor believed that the SS returned to the home with the parents.

OCFS Review Results:
The investigation was initiated timely, a CPS history check was completed, and the source was contacted. Attempted home visits were made from 08/03/2025 through 08/10/2025 when the family was located, and safety was assessed. There was no documentation that the SS was interviewed regarding safety or the allegations; however, she was observed on multiple occasions though the investigation. Despite supervisory direction to interview the SS there was no documentation that the SS was asked key safety-related questions or allegation related information. Documentation did not reflect the SS was spoken to during the face-to-face contacts.

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

The family had no known history of CPS involvement 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