Child Fatality Report

Report Identification Number: BU-25-001

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

Issue Date: May 20, 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 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
Age: 30 day(s)
Jurisdiction: Erie
Gender: Female
Date of Death: 01/04/2025
Initial Date OCFS Notified: 01/04/2025

Presenting Information

An SCR report alleged on 01/04/25, while in the care of the mother, the 30-day-old child sustained trauma to her sternum causing a contusion. The internal injuries from the trauma resulted in the child bleeding from her nose and mouth. The mother did not immediately contact EMS and instead, called the father. The father called 911 and EMS arrived at the home at about 11:03 AM and began CPR. The child was transported to the hospital at 12:04 PM and arrived at 12:10 PM. The child was pronounced deceased at an unknown time. The mother did not have an explanation for the child's injuries or death.

Executive Summary

This report concerns the death of the 30-day-old child that occurred on 01/04/25. A report was made to the SCR on the same day alleging while in the care of the mother, the child sustained trauma to her sternum and the child subsequently died. At the time of her death, the child resided with her mother and 1-year-old sibling. The sibling was assessed to be safe in the care of the mother.

Erie County Department of Social Services (ECDSS) coordinated investigative efforts with law enforcement upon receipt of the SCR report. The outcome of the criminal investigation remained unknown. An autopsy was performed, and the report noted the cause of death to be asphyxia due to unsafe sleep. The manner of death was an accident.

The mother was interviewed and reported placing the child to sleep in the same bed as her. The mother placed a maternity pillow between them and went to sleep. When the mother awoke, the child was unresponsive with blood coming from her nose. They were no longer separated by the maternity pillow. The mother called 911 and performed CPR at the instruction of the operator. First responders arrived, took over resuscitation efforts and transported the child to the hospital where she was pronounced deceased. The mother called the father and when he arrived at the home, the child was receiving lifesaving efforts. The father reported not having concerns for the mother’s care of the children.

ECDSS made collateral contacts with EMS, the mother’s mental health counselor and the pediatrician. There were no reported concerns aside from the unsafe sleeping environment.

Safety Assessments and required reports were completed timely and accurately. Inadequate Guardianship and DOA/Fatality were appropriately substantiated. Internal Injuries, Lack of Medical Care, and Lacerations/Bruises and Welts were unsubstantiated. The Investigation Conclusion Narrative reflected that the mother placed the child in an unsafe sleeping environment and later found her unresponsive. There were no internal injuries to the child and there was not a contusion to her chest.

Although the record reflected the father was not present when the mother placed the child to sleep, the father reported being aware the child would sleep in a bassinet or swing when he was at the home. The swing was an unsafe sleeping environment. The record also reflected that the father was aware the mother would sleep in bed with the child, as well as with a maternity pillow, bottle and pacifier. The father was aware of the unsafe sleeping environment and failed to intervene. There was no documentation that Inadequate Guardianship against him was considered.

ECDSS offered the parents bereavement services and burial assistance. The mother was previously engaged in counseling and continued her treatment. The father was not engaged in services. The case was closed timely on 02/24/25.

PIP Requirement

ECDSS will submit a PIP to the Buffalo Regional Office within 30 days of the receipt of this report. The PIP will identify action(s) the ECDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ECDSS will review the plan and revise as needed to address ongoing concerns.

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 decision to close the case was appropriate.

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
Casework activity was not commensurate with case circumstances as the father was aware the mother placed the child in an unsafe sleeping environment, he did not intervene, and Inadequate Guardianship was not added and substantiated against him.

Required Actions Related to the Fatality

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

Issue:	Determination of Nature, Extent and Cause of Conditions (Report)
Summary:	Although the BF reported knowing the SM bedshared with the SC and would sleep with a maternity pillow, Inadequate Guardianship against him was not documented to have been considered.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(d)
Action:	ECDSS will address new concerns as they arise with all applicable caregivers, in an effort to determine whether the action(s)/inaction(s) constitute as abuse or maltreatment.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 01/04/2025 **Time of Death:** 02:30 PM (Approximate)

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

County where fatality incident occurred: Erie
Was 911 or local emergency number called? Yes
Time of Call: 11:04 AM
Did EMS respond to the scene? Yes
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	Female	30 Day(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	22 Year(s)
Deceased Child's Household	Sibling	No Role	Male	1 Year(s)
Other Household 1	Father	No Role	Male	21 Year(s)

LDSS Response

On 01/04/25, ECDSS received the fatality report from the SCR. Within the first 24 hours of the investigation, ECDSS contacted the source of the report, completed a CPS history check, coordinated investigative efforts with law enforcement and notified the DA and ME's offices of the death. The sibling was assessed to be safe with the mother.

The mother was interviewed and reported that the child was fine the day prior to her death. The mother reported placing the child on her back in an adult-sized bed and then they both fell asleep. The mother reported wrapping the child in a knit blanket and that there was a maternity pillow in the bed, separating them. When the mother awoke around 7:00 AM, she fed the child, and they went to sleep. Around 10:50 AM, the mother woke and found the child cold to the touch and not breathing. At that time, the child was closer to the mother and was described to be close to her right breast. The mother reported that part of the maternity pillow was between her legs and was "not directly separating them." The mother called 911 and performed CPR. She contacted the father who came to the home while first responders were preforming lifesaving measures. The mother denied the child's face was covered and noted that the child had clenched fists and blood on her mouth. The mother was aware of safe sleeping recommendations.

The father was interviewed and stated he did not have concerns for the care the mother provided to the children. He reported that the child would sleep in a swing or bassinet when he was present, but noted he had awareness that the mother slept in the bed with the child when he was not there. He reported the mother would sleep with the maternity pillow between her and the child, and that the mother would also have a bottle and pacifier nearby. The father said the mother called him and notified him of the situation, he went to the home, and first responders were already there.

ECDSS gathered information from hospital staff who stated the child was transported to the hospital while in cardiac arrest and that it was believed the child was suffocated while bedsharing.

EMS reported that the child had an "odd mark" on her chest, and that the child was deceased for a while as rigor mortis had set in. The pediatrician did not have concerns for the child.

ECDSS appropriately determined the allegations against the mother; however, did not add Inadequate Guardianship against the father. The family was offered services, and the case was closed timely.

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: Forensic Pathologist

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
070588 - Deceased Child, Female, 30 Day(s)	070589 - Mother, Female, 22 Year(s)	DOA / Fatality	Substantiated
070588 - Deceased Child, Female, 30 Day(s)	070589 - Mother, Female, 22 Year(s)	Inadequate Guardianship	Substantiated
070588 - Deceased Child, Female, 30 Day(s)	070589 - Mother, Female, 22 Year(s)	Internal Injuries	Unsubstantiated
070588 - Deceased Child, Female, 30 Day(s)	070589 - Mother, Female, 22 Year(s)	Lack of Medical Care	Unsubstantiated
070588 - Deceased Child, Female, 30 Day(s)	070589 - Mother, Female, 22 Year(s)	Lacerations / Bruises / Welts	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 parent(s) and other care givers at the time of and/or in response to the fatality? Yes

Explain:

The mother was previously engaged in therapy and continued to attend. It remained unknown if the parents accepted the 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)
11/26/2023	Sibling, Male, 9 Months	Grandparent, Female, 60 Years	Inadequate Guardianship	Substantiated	No

Report Summary:
An SCR report alleged that on 11/25/23, the paternal grandmother (PGM) punched the maternal grandmother (MGM) in the back of the head while the MGM was holding the sibling. The sibling did not sustain physical injuries.

Report Determination: Indicated

Date of Determination: 12/15/2023

Basis for Determination:
The Investigation Conclusion Narrative noted the PGM stated the MGM was the aggressor and that she could not hit the MGM in the way described due to issues with her hands. LE records noted the PGM was arrested for harassment.

OCFS Review Results:
The investigation was initiated timely, and the source was contacted. Home visits were made, and the family was interviewed. Safe sleeping information was provided to all adults. The Safety Assessments were completed timely and accurately reflected case circumstances. The investigation was closed timely.

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 is no known CPS history outside of New York.

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 appreciate the opportunity given to 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. Upon further review of the fatality investigation by ECDSS, we must unfortunately concur with the compliance issue cited by the reviewer. As a corrective action, ECDSS will reinforce with the chain of command overseeing the fatality investigations, as well as with all CPS Team Leaders the necessity of considering and addressing any new concerns as they arise with all applicable caregivers to determine whether the actions/inactions of the caregiver constitute abuse or maltreatment.

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