Child Fatality Report

Report Identification Number: BU-25-005

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

Issue Date: Aug 12, 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: 2 month(s)
Jurisdiction: Erie
Gender: Male
Date of Death: 03/05/2025
Initial Date OCFS Notified: 03/05/2025

Presenting Information

On 3/5/2025, at 1:30am, the subject mother breastfed the 2-month-old male subject child and placed him in her bed to sleep with her and the 5-year-old SS. The 19-year-old adult sibling entered the room to wake the 5-year-old SS at 7:35am and realized that the SC was not breathing. One of the females in the residence contacted 911 and was given instructions on how to perform cardiopulmonary resuscitation (CPR). Law enforcement arrived at the home where they resumed CPR on the SC who was on the dining room table in the home. The fire department arrived and took over CPR while moving the SC to a couch in the living room. When EMS arrived at the home, they continued CPR on the SC. While in the home, the SC was pronounced deceased at 7:58am. The unsafe sleeping arrangement is believed to have contributed to the SC's death.

Executive Summary

This report concerns the death of the 2-month-old male subject child. On 03/05/2025, the Erie County Department of Social Services (ECDSS) received an SCR report regarding the subject child's death which occurred on the same day. It was reported that on 03/05/2025, at approximately 7:30am, the 19-year-old SS went in the mother’s room to wake the 5-year-old SS and discovered the subject child under the covers in bed with the subject mother and 5-year-old sibling, the subject child was unresponsive, and Emergency Medical Services were called. Emergency Medical Services arrived and preformed life saving measures; however, these efforts were unsuccessful, and the subject child was pronounced deceased, in the home at 7:58am. At the time of the subject child's death, he resided with his mother, 5-year-old sibling,8-year-old sibling, 16-year-old sibling ,19-year-old sibling, 49-year-old uncle, and 10-year-old-cousin. On 03/05/2025, ECDSS assessed the siblings to be safe while in the mother’s care. The BF of the SC died on 05/01/2024, before the SC was born. The death was believed to be a drug overdose; however, an autopsy was not conducted at the time of his death.

ECDSS coordinated investigation efforts with law enforcement. Law enforcement found nothing suspicious in the home nor with the mother’s statement regarding the fatal incident. Law enforcement and the DA reported no arrests or criminal activity regarding the case. Law enforcement believed that the death was directly related to bedsharing. Law enforcement coordinated investigative efforts with the medical examiner and an autopsy was scheduled for 03/05/2025.

The medical examiner verified an autopsy was completed on 03/05/2025. Documentation noted the medical examiner's preliminary findings were undetermined. It was further reported there were no visible injuries or undiagnosed medical conditions, no signs of abuse, maltreatment, or malnutrition. The medical examiner reported that the death was consistent with bedsharing. The final autopsy was pending further studies and there was no cause or manner listed at the time this report was written.

The allegations of DOA/Fatality and Inadequate Guardianship against the subject mother regarding the subject child were substantiated. ECDSS determined that there was a fair preponderance of evidence to support the allegations. ECDSS noted that there was evidence that bedsharing played a role in the subject child's death. The subject mother and adult sibling both admitted that the subject mother was bedsharing with the subject child, and with the 5-year-old sibling. The adult sibling found the subject child in the subject mother’s bed, face down, and under blankets when the adult sibling entered the mother’s room to wake the surviving sibling for school. The subject mother was still sleeping when the adult sibling went into the room. ECDSS observed a bassinet, and a pack n' play in the home, and it was confirmed that the

subject mother did have appropriate and safe sleeping arrangements but chose not to utilize them on the day of the fatal incident or on several other occasions. It was documented in pediatrician notes that the subject mother received education on safe sleep practices, and the dangers of bedsharing; however, the subject mother still chose to put the subject child in the adult bed with her and the 5-year-old sibling, placing the subject child at risk of harm and death. The investigation closed on 05/04/2025. ECDSS offered grief counseling to the subject mother and surviving siblings. ECDSS gave the subject mother a packet of resources that included funeral cost assistance. ECDSS also offered assistance if the family needed it in the future.

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

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes

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

Explain:
The case work activity was commensurate with the case circumstances.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Child Fatality Report

Incident Information

Date of Death: 03/05/2025 **Time of Death:** Unknown

Time of fatal incident, if different than time of death: 07:58 AM

County where fatality incident occurred: Erie
Was 911 or local emergency number called? Yes
Time of Call: 07:35 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	Aunt/Uncle	No Role	Male	49 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	2 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	41 Year(s)
Deceased Child's Household	Other - cousin	No Role	Female	10 Year(s)
Deceased Child's Household	Sibling	No Role	Female	19 Year(s)
Deceased Child's Household	Sibling	No Role	Male	16 Year(s)
Deceased Child's Household	Sibling	No Role	Male	6 Year(s)
Deceased Child's Household	Sibling	No Role	Male	8 Year(s)

LDSS Response

Upon receipt of the SCR report, ECDSS began their investigation within 24 hours, coordinated efforts with law enforcement, the DA, the medical examiner, contacted the source of the report and completed a CPS history check.

The SM was interviewed regarding the events leading up to the fatal incident. The SM reported that the evening prior to the fatal incident she fed the SC at approximately 11:00pm and then laid down with the SC in the SM's bed where the 5-year-old sibling was already sleeping. She explained that she woke to the 19-year-old SS at approximately 7:30am, stating

that the SC was face down, not breathing and under the covers. The SM immediately picked the SC up and realized the SC was not breathing and turning blue. The SM went downstairs with the SC and started CPR. The 19-year-old SS called 911, and they assisted the SM while she administered CPR until EMS arrived. EMS arrived and took over lifesaving measures to no avail. The medical examiner was contacted, and the family spent time with the deceased child before the SC was transported to the morgue. The SM explained that she was aware of safe sleep practice; however, regularly bedshared with the SC. The SM reported that there was a pack n' play as well as a bassinet in the home located on the first floor at the time of the SC's death.

The 19-year-old SS confirmed the SM's recollection of the events on the morning of the fatal incident. The SS's all reported that the SM usually bedshared with the SC; however, there were occasions the SC slept in the pack n' play or the swing.

ECDSS contacted appropriate collaterals to determine safety. Collateral contacts as well as school staff and the pediatrician all reported no concerns for the safety of the surviving siblings. The Safety Assessments and Risk Assessment were completed accurately and timely. ECDSS appropriately determined the allegations and closed the case with services being offered for any of the family's future needs.

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?Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
071774 - Deceased Child, Male, 2 Month(s)	071775 - Mother, Female, 41 Year(s)	DOA / Fatality	Substantiated
071774 - Deceased Child, Male, 2 Month(s)	071775 - Mother, Female, 41 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐

All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

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:
ECDSS offered bereavement counseling to all surviving siblings. At the time of the case closure the SM was trying to decide which counselor to work with from the list of resources that she received.

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:
ECDSS offered bereavement services to the SM as well as a packet of available resources the SM had available if needed. At the time of case closure the SM was trying to decide which counseling services she would utilize.

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)
10/02/2023	Sibling, Female, 17 Years	Mother, Female, 39 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Male, 15 Years	Mother, Female, 39 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 8 Years	Mother, Female, 39 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 5 Years	Mother, Female, 39 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 4 Years	Mother, Female, 39 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
On 10/02/2023, ECDSS received an SCR report with concerns that the SM was selling drugs out of the home. It was reported that the SSs were in the home when the drug sales were occurring.

Report Determination: Unfounded | **Date of Determination:** 01/05/2023

Basis for Determination:
On 01/05/2023, ECDSS determined that the allegation of IG against the SM regarding the SSs was unsubstantiated. During both announced and unannounced home visits there was no evidence that the SM was selling drugs from the home. The SM and SSs all denied any drug activity in the home. Law enforcement denied any known drug related incidents from the home. Collateral contacts had no concerns for drug related incidents in the home and ECDSS deemed the children safe.

OCFS Review Results:
Upon receiving the SCR report ECDSS contacted the source of the report and completed a history check. ECDSS completed interviews with all household members and assessed the safety of the SSs. The initial Safety Assessment was completed on 10/12/2023, on day 10; however, was completed accurately. The Risk Assessment was completed timely and accurately. The evidence gathered was consistent with the case determination.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
03/13/2023	Sibling, Female, 8 Years	Mother, Female, 39 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Male, 6 Years	Mother, Female, 39 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
On 03/13/2023, ECDSS received an SCR report with concerns that the SM was placing the 8-year-old and 5-year-old SSs in an uber by themselves to get the children to school. The report alleged that the children were not mature enough to use this form of transportation alone.

Report Determination: Unfounded | **Date of Determination:** 04/14/2023

Basis for Determination:
On 04/14/2023, ECDSS determined the allegation of IG against the SM regarding 2 SSs were unsubstantiated. The SM and children as well as the BF of the 17-year-old SS all reported that the 17-year-old SS rides with the younger children in the uber, drops the siblings off to their school and then takes the uber to her school.

OCFS Review Results:
Upon receipt of the SCR report, ECDSS contacted the source of the report and completed a history check. ECDSS interviewed all household members, including the SM and all the SSs. ECDSS suggested that the SM change the bus route so the children could ride the bus; however, determined the 17-year-old sibling was an appropriate supervisor while riding in the uber. ECDSS completed Safety Assessments timely and accurately. The Risk Assessment was consistent with the case circumstances. ECDSS's closing determination reflected evidence gathered during the investigation.

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

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

CPS report dated 07/14/2011- The BF of the 16-year-old SS and the SM had substantiated allegations of Inadequate Guardianship regarding the 19-year-old SS and 16-year-old SS. At the time there had been two domestic incidents in which a knife had been used. On one of the occasions both adults had to receive staples to close the wounds from the altercation. During this altercation the 15-year-old SS was in the home. The severity of the incidents of DV had escalated, which put the children at a high risk of harm. At the time the SM accepted services, a neglect petition was filed, and the children were in the 1017 custody of the maternal grandmother. Orders of protection were issued against both parents in favor of the children. The OA was the biological father of both children. The SM was allowed supervised visits with the children. The allegations were substantiated, and a services case was opened for ongoing Family Court activity and the ongoing provision of preventive services.

CPS report dated 9/10/21- The allegations of IG and XCP against the SM with respect to OC was unfounded. Allegations that the SM used XCP on the OC for discipline. The OC had no marks or bruises when observed.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Preventive Services History

On 07/29/2011 a services case was opened regarding an indicated CPS investigation. The report was regarding DV between the SM and the biological father of the SS's (OA). A 1017 custody petition was filed, and the MGM received custody of the children with the SM having supervised visits. The preventive case was closed on 03/26/2013. The SM completed the requirements of the court order, and both children were returned to her. The OA did not complete any requirements, had an OOP in place regarding the SM and children and it was determined that if he wanted visits with the children then he would need to complete parenting, mental health and substance treatment and petition the court at that time.

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 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. We are pleased that OCFS found that the fatality investigation was conducted appropriately and that there are no required actions related to the fatality.

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