Child Fatality Report

Report Identification Number: BU-25-007

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

Issue Date: Sep 04, 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 year(s)
Jurisdiction: Erie
Gender: Male
Date of Death: 03/20/2025
Initial Date OCFS Notified: 03/20/2025

Presenting Information

The Erie County Department of Social Services (ECDSS) received two SCR reports on 3/20/25, alleging that on 3/20/25, while in the care of the godmother (OA1) and the godmother (OA2), the 4yo male SC was unattended for an unknown period of time enabling him to get out of the home. After an unknown amount of time passed, the OAs went looking for the SC and found him face down in the swimming pool. He was unresponsive. Emergency Medical Personnel (EMS) was called. When they arrived at the home, they immediately began to administer cardiopulmonary resuscitation (CPR); however, the SC never regained consciousness. The SC was pronounced deceased at 5:17PM.

Executive Summary

On 3/20/25, Erie County Department of Social Services (ECDSS) received an SCR report regarding the death of the 4-year-old male subject child. The SCR report contained allegations of DOA/Fatality, Inadequate Guardianship, and Lack of Supervision against the godmothers (OA1 and OA2). At the time of his death, the subject child resided with his godmothers and their 11-year-old son (OC). The subject child had five surviving siblings. An 8-year-old surviving sibling lived with the biological mother where he was deemed safe. The four other surviving siblings ages 13, 12, 11, and 10 resided in Kin-Gap placements, they did not have any contact with the subject child.

Through a joint investigation with law enforcement, it was learned on 3/20/25, the subject child was in the care of his godmothers. Around 4:59PM, the family went to the home of a relative to do laundry. While the godmothers were trying to figure out how to operate the washing machine, the subject child was able to get out of the residence where he drowned in the swimming pool located in the back yard of the home. When the godmothers realized the subject child was missing, they immediately started to search for him. They found the subject child floating face down in the swimming pool. One of the godmothers immediately initiated life saving measures while the other godmother contacted 911. When emergency medical services arrived, they took over lifesaving measures and transported the subject child to the hospital. Despite efforts, the subject child was pronounced deceased on 3/20/25 at 5:17PM.

ECDSS communicated with the medical examiner's office and learned that an autopsy was performed. The autopsy report noted that a complete examination failed to demonstrate any significant injury or natural disease that would explain the death. Microscopic examination of the lungs showed aspirated foreign material and slight distension of the alveoli that may be seen in drowning deaths. Toxicology testing was performed and was negative. The manner of death was listed as an accident and the cause of death was listed as drowning.

ECDSS communicated with law enforcement. Law enforcement reported no suspicion of foul play. No criminal charges were filed against the godmothers.

ECDSS made the appropriate decision to substantiate the allegations of DOA/Fatality, Inadequate Guardianship, and Lack of Supervision against the godmothers as there was a fair preponderance of evidence that the godmothers contributed to the child's death. The investigation was indicated and closed.

The family was offered bereavement services by ECDSS; however, declined as they were engaged in grief counseling referred by their son's school. Prior to the investigation closing, ECDSS followed up with the family. The godmothers

reported that things were going well. ECDSS went over water safety with the godmothers and reiterated that their child must have adequate supervision when he was around pools or any other bodies of water. The godmothers agreed that they would not allow their son to be around water unsupervised.

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 allegations were determined appropriately.

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.

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: 03/20/2025 **Time of Death:** 05:17 PM

Time of fatal incident, if different than time of death: 04:24 PM

County where fatality incident occurred: Erie
Was 911 or local emergency number called? Yes
Time of Call: Unknown
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	Male	4 Year(s)
Deceased Child's Household	Other Adult - OA1	Alleged Perpetrator	Female	30 Year(s)
Deceased Child's Household	Other Adult - OA2	Alleged Perpetrator	Female	29 Year(s)
Deceased Child's Household	Other Child - Child of the OAs	No Role	Male	11 Year(s)

LDSS Response

Upon receipt of the SCR report, ECDSS initiated their investigation within 24 hours, completed a CPS history check, coordinated their efforts with law enforcement, and notified the district attorney of the fatality. ECDSS immediately initiated their investigation and learned that there was one other child (OC) who resided in the home of the SC at the time of the fatality. He was deemed safe in the care of the OAs.

On 3/21/25, ECDSS interviewed both the OA1 and OA2 in their home. The OA's provided a timeline of events. They explained that the SC and the OC share the same father, and did not have a relationship with the BM or her children. One day the BM was posting on social media that she was overwhelmed and in trouble. She threatened suicide and was begging for help. The OA2 stated she sent the BM a message offering to care for the children so the BM could try to get the help she needed. The OA2 advised that when the SC was 2-months-old, the BM called them and asked them to be his Godparents. They agreed and the SC had been in their care ever since. For the past three years, the BM has had visitation

with the SC a weekend or two a month. The BM signed paperwork giving them medical rights; however, custody of the SC remained informal. The godmothers expressed they thought of the SC as their son. They advised on 3/30/25 at around 4:59PM, all four of them went to a relative's home to do laundry. When they arrived at the home, they were standing in the foyer and the SC kept pointing outside indicating that was where he wanted to go. They told him they would go outside later. They all went to the basement to get the laundry started. The SC and OC were playing arcade games. After about five minutes, they both looked over and realized that the SC was missing. The OA1 looked for the SC upstairs, and when she could not find him, she ran to the backyard and searched for him in the pool. Initially, she did not see him, the pool was very dirty, and the OA1 walked back in the house. The OA1 and OA2 began calling out for and running all over the house looking for the SC. The OA1 said she went back outside and saw the SC floating face down in the swimming pool. The OA1 immediately took the SC out of the pool. She laid him down on the deck and began administering CPR. She stated at one point she felt his heartbeat and he opened his eyes and vomited. The OA2 ran into the house and called 911. When EMS arrived, they took over life-saving measures. The SC was transported via ambulance to the hospital. They drove themselves to the hospital where upon arrival, they were advised that the SC had passed away. The OC was interviewed and corroborated his mothers' recollection of events.

ECDSS interviewed the BM and PS at their residence. The 8yo SS was present as well. He would not speak to the worker. No concerns were noted regarding the SS. Both the BM and PS agreed that the fatal event was due to poor supervision; however, they believe it was an accident. They did not have any concerns for the OA1 or OA2. The BM denied that she blamed the OAs for the SC's death, she knows it was an accident; however, she believed that there should have been a gate preventing the SC from being able to access the deck.

ECDSS made several attempts to locate the BF to no avail. He was never informed of the death by ECDSS.

ECDSS communicated with the SC's pediatrician. There were no concerns noted.

The CPS investigation was closed timely on 5/19/25. The family declined bereavement services offered by ECDSS, and began grief counseling recommended by the OC's school counselor.

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
071855 - Deceased Child, Male, 4 Year(s)	071856 - Other Adult - OA1, Female, 30 Year(s)	DOA / Fatality	Substantiated

071855 - Deceased Child, Male, 4 Year(s)	071856 - Other Adult - OA1, Female, 30 Year(s)	Inadequate Guardianship	Substantiated
071855 - Deceased Child, Male, 4 Year(s)	071856 - Other Adult - OA1, Female, 30 Year(s)	Lack of Supervision	Substantiated
071855 - Deceased Child, Male, 4 Year(s)	071857 - Other Adult - OA2, Female, 29 Year(s)	DOA / Fatality	Substantiated
071855 - Deceased Child, Male, 4 Year(s)	071857 - Other Adult - OA2, Female, 29 Year(s)	Inadequate Guardianship	Substantiated
071855 - Deceased Child, Male, 4 Year(s)	071857 - Other Adult - OA2, Female, 29 Year(s)	Lack of Supervision	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	☐	☐	☐	☐	☐	☒

Additional information, if necessary:
The family was receiving grief counseling through a referral made by the OCs school. ECDSS gave the BM resources for grief counseling.

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 provided the family with resources for bereavement counseling.

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 provided the family with resources for bereavement counseling.

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

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

02/18/20-4/16/20: IF/C/S, IG and LS were unsubstantiated against the OA1 re: 5yo OC, 1yo OC, 5yo OC, 1yo OC, 2yo OC, and 13yo OC.

02/18/20-4/16/20: IF/C/S and IG were unsubstantiated against the OA1 re: 5yo OC.

Known CPS History Outside of NYS

There is no known CPS History outside of NYS.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity.

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. 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