Child Fatality Report

Report Identification Number: BU-25-010

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

Issue Date: Nov 03, 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: 2 month(s)
Jurisdiction: Erie
Gender: Male
Date of Death: 06/08/2025
Initial Date OCFS Notified: 06/08/2025

Presenting Information

The SCR report alleged that on 6/7/25, the mother placed the subject child on an adult-sized bed to sleep for the night. At 12:45 AM on 6/8/25, the mother found the child unresponsive on the bed. The mother called 911 and alerted the grandfather, who resided across the street. The grandfather came to the home and performed cardiopulmonary resuscitation until law enforcement arrived. Law enforcement performed cardiopulmonary resuscitation until emergency medical services arrived. The subject child was transported to the hospital and pronounced deceased at 2:10 AM. The subject child's unsafe sleeping arrangement was believed to have contributed to his death. In addition, the home was found to be cluttered. The sibling's bedroom was unsanitary, with feces on his bed and garbage on the floor. The grandmother was aware of the poor living conditions and did not address the situation. The sibling was not home on 6/8/25.

Executive Summary

This fatality report concerns the death of the 2-month-old male subject child that occurred on 6/8/25. The SCR report contained allegations of DOA/Fatality, Inadequate Guardianship, and Inadequate Food/Clothing/Shelter. At the time of his death, the subject child resided with his mother and 2-year-old sibling. The father resided at a separate residence, but frequently stayed at the mother’s home. There was a 1-year-old half-sibling who resided with her mother and had minimal contact with the father.

Erie County Department of Social Services (ECDSS) completed casework and collateral contacts and learned that on 6/7/25, the mother placed the subject child on a U-shaped pillow on her king-sized bed, covered him with a blanket, and went downstairs. Around 11:00 PM, the mother went upstairs to feed the subject child and then went back downstairs. Approximately an hour and a half later, the mother went to check on the subject child again. The mother found the subject child with the blanket covering one nostril and his hand over his face. The subject child appeared blue and was cold to the touch. The mother called the maternal grandmother and grandfather, who lived across the street from the mother. The mother called 911, and emergency medical services responded to the home. The subject child was transported to the hospital, where he was pronounced deceased at 2:10 AM on 6/8/25.

An autopsy was completed. The cause of death was positional asphyxia, and the manner of death was accident. The medical examiner noted the subject child had a prominent diaper rash and acute bronchitis, and viral studies were positive for rhinovirus/enterovirus and metapneumovirus. The medical examiner stated the U-shaped pillow slid under the subject child’s head/neck region, and the subject child asphyxiated due to the position on the pillow. The subject child had two bruises near his ear, though the medical examiner stated these could have been from resuscitation efforts. No charges had been filed related to the subject child’s death.

Bereavement services were offered to the family. The allegation of DOA/Fatality was inaccurately substantiated against the father. The father was not present at the mother’s home at the time of the subject child’s death. The allegation of Inadequate Food/Clothing/Shelter was inaccurately substantiated against the mother and father regarding the subject child. Although a safe sleeping environment was not being utilized for the subject child, safe sleeping provisions were available. Two bassinets were observed in the mother’s bedroom. All other allegations were appropriately determined, including the allegations against the grandmother who did not reside in the home. ECDSS completed all other casework

activity and documentation timely and accurately. The siblings were deemed safe with their respective caregivers. The case was indicated and closed on 8/6/25.

PIP Requirement

This review resulted in a citation related to casework practice. In response, ECDSS will submit a PIP to the Buffalo Regional Office within 30 days of receipt of this report. The PIP will identify what action(s) the ECDSS has taken, or will take, to address the cited issue(s). For citations where a PIP is currently implemented, ECDSS 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?** Yes

Explain:

While the overall determination of the case was appropriate, not all allegations were accurately determined. The allegation of DOA was inappropriately substantiated against the SF, and the allegation of IF/C/S was inappropriately substantiated against the SM and SF.

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. Some of the allegations were inaccurately determined.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	The allegation of DOA against the SF, and IF/C/S against the SM and SF were inappropriately substantiated. The SF was not present at the time of the SC's death. Although the parents were not utilizing a safe sleeping space, one was available.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	ECDSS will refer to the CPS Program Manual when determining the appropriateness of allegations, and will consult with the Buffalo Regional Office if further guidance is needed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/08/2025 **Time of Death:** 02:10 AM

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: 12:53 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	Male	2 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	24 Year(s)

Deceased Child's Household	Mother	Alleged Perpetrator	Female	20 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	2 Year(s)
Other Household 1	Grandparent	Alleged Perpetrator	Female	40 Year(s)

LDSS Response

Upon receipt of the SCR report, ECDSS coordinated their investigation with LE, notified the DA's office, completed a CPS history check, contacted collateral sources, interviewed all present parties, and assessed the safety of the 2yo SS and 1yo half-sibling.

ECDSS interviewed the SM and SF and learned that on 6/7/25, the SM, SF, and a family friend were present at the SM's home. The 2yo SS was with the PGM until approximately 9:00 PM that evening. The SM reported that the family friend came over around 6:00 PM, left for approximately 20 minutes around 8:00 PM, and then returned to her home. The SF reported that the SC was in the living room with him, the SM, and the family friend. The SM reported that the SF and friend helped her care for the SC, but it was unknown to what extent. The SF left the SM's home around 10:30 PM. At an unknown time, the SM put the SC on her king-sized bed and went downstairs to watch a movie with the family friend. Around 11:00 PM, the SM went upstairs to check on the SC. The SM fed the SC and attempted to burp him, but he had fallen asleep. The SM placed the SC on his back, on a U-shaped pillow on her king-sized bed with a blanket covering him, and returned downstairs. Around 12:30 AM on 6/8/25, the SM went to check on the SC and found him unresponsive, with the blanket covering one of his nostrils and his hand over his face. The SM called for the family friend who was still downstairs, and then called the MGM, who resided across the street. The MGM advised the SM to call 911, hung up, and went to the SM's residence with the MGF. The SM called 911, and the MGM began CPR. The MGF spoke with 911 and took over CPR until EMS responded. The SC was transported to the hospital, where he was later pronounced deceased.

The family friend was interviewed; however, he provided contradictory information from the SM and SF. The friend stated he went to the SM's home around 4:00 or 5:00 PM to hang out with the SM and SF. He stated he left for a brief time, but was unable to state exactly when or for how long. The friend stated the SC was never brought downstairs, and he never went upstairs until the SM found the SC unresponsive.

During home visits to the SM's residence, there were two bassinets observed in the SM's bedroom, which EMS stated appeared not to have been used and were observed with clothing in them. EMS also observed the SM's bed to contain bulky pillows and blankets. The SM and SF reported that the SC was put to sleep on the U-shaped pillow on the SM's bed during the day for naps, but was always placed in the bassinet at night. The parents reported that the SC did not like to lie flat on his back. The SF reported that sometimes he and the SM would bring the SC into bed with them in the morning while they were waking up. The SM was aware of safe sleep guidelines and denied bedsharing.

The SM reported the SC had a stuffy nose and was given a pain and fever-reducing medication, but did not have a fever. The SC was last seen by the pediatrician on 5/12/25, and there were no noted concerns. The SC had a scheduled doctor's appointment for 6/9/25 for his 2-month well-child visit and vaccinations. The parents reported they were using diaper cream for the SC's diaper rash and denied that it required medical attention. The SM stated they had switched brands of diapers due to the SC getting a rash from the ones previously used.

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
072518 - Deceased Child, Male, 2 Month(s)	072519 - Mother, Female, 20 Year(s)	DOA / Fatality	Substantiated
072518 - Deceased Child, Male, 2 Month(s)	072519 - Mother, Female, 20 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
072518 - Deceased Child, Male, 2 Month(s)	072519 - Mother, Female, 20 Year(s)	Inadequate Guardianship	Substantiated
072518 - Deceased Child, Male, 2 Month(s)	072520 - Father, Male, 24 Year(s)	DOA / Fatality	Substantiated
072518 - Deceased Child, Male, 2 Month(s)	072520 - Father, Male, 24 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
072518 - Deceased Child, Male, 2 Month(s)	072520 - Father, Male, 24 Year(s)	Inadequate Guardianship	Substantiated
072518 - Deceased Child, Male, 2 Month(s)	072522 - Grandparent, Female, 40 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
072518 - Deceased Child, Male, 2 Month(s)	072522 - Grandparent, Female, 40 Year(s)	Inadequate Guardianship	Unsubstantiated
072521 - Sibling, Male, 2 Year(s)	072519 - Mother, Female, 20 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
072521 - Sibling, Male, 2 Year(s)	072519 - Mother, Female, 20 Year(s)	Inadequate Guardianship	Unsubstantiated
072521 - Sibling, Male, 2 Year(s)	072520 - Father, Male, 24 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
072521 - Sibling, Male, 2 Year(s)	072522 - Grandparent, Female, 40 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
072521 - Sibling, Male, 2 Year(s)	072520 - Father, Male, 24 Year(s)	Inadequate Guardianship	Unsubstantiated
072521 - Sibling, Male, 2 Year(s)	072522 - Grandparent, Female, 40 Year(s)	Inadequate Guardianship	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?	☐	☒	☐	☐

Explain as necessary:
No children needed to be removed as a result of the fatality.

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:
Fatality-related services were offered to the parents; however, the SF declined services. The SM was working with her physician to get connected with grief 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

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

There is no CPS investigative history in NYS within three years prior to the fatality.

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

There was no CPS investigative history more than three years prior to the fatality.

Known CPS History Outside of NYS

There was no known CPS history outside of New York State.

Legal History Within Three Years Prior to the Fatality

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

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 review of the required actions related to the fatality investigation, we must concur that the identified citations are accurate. Specifically, we agree that allegations were inappropriately substantiated. These concerns have been addressed with the investigating caseworker and the supervising Team Leader, who approved the investigation. As a corrective action, the above-identified concerns will be reviewed and discussed at our monthly CPS team leader meeting.

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