Office of Children and Family Services

Child Fatality Report

Report Identification Number: RO-25-005

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

Issue Date: May 21, 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: Monroe
Gender: Male
Date of Death: 01/27/2025
Initial Date OCFS Notified: 01/27/2025

Presenting Information

An SCR report alleged the mother fed the 2-month-old child a bottle around 7:00 AM on 01/27/25. The mother then put the child back in his crib. Around 7:20 AM, the mother found the child cold and unresponsive. EMS was contacted and the child was brought to the hospital at 8:20 AM where lifesaving measures were performed to no avail. The child was pronounced deceased at 8:42 AM. The parents did not have a plausible explanation for the death. A subsequent report was received on the same day with allegations against the grandmother.

Executive Summary

This report concerns the death of the 2-month-old child that occurred on 01/27/25. A report was made to the SCR on the same day that alleged the mother fed the child and placed him to sleep in a bassinet around 7:00 AM. Approximately 20 minutes later, the mother discovered the child was cold to the touch and was unresponsive. EMS was contacted and the child was transported to the hospital via ambulance, where he was pronounced deceased at 8:42 AM. A subsequent report alleged similar concerns and noted the maternal grandmother was home and had no explanation for the death. At the time of the death, the child resided with the mother, the grandmother and the grandmother's partner. There were no siblings or other children in the home. The father resided outside of the home.

Monroe County Department of Human Services (MCDHS) coordinated investigative efforts with law enforcement upon receipt of the SCR reports. The outcome of the criminal investigation remained pending. An autopsy was performed; however, the report was not yet available at the time of this writing. The medical examiner noted finding several old, healing fractures to the child and noted that the injuries were likely due to non-accidental trauma; however, the injuries were unlikely to have caused the death.

The mother was interviewed and reported feeding the child prior to placing him in his bassinet with a blanket over his lower extremities. There was also a teddy bear in the sleeping area. When she checked on the child approximately 20 minutes later, his eyes were open, yet he was cold to the touch, and he was unresponsive. The mother screamed, went to the grandmother’s room, and they called 911. The mother performed rescue breaths until first responders arrived and transported the child to the hospital where he was pronounced deceased. The grandmother's partner and father were not present at the time of the incident, and did not have concerns for the care of the child.

MCDHS completed the 24-Hour and 30-Day Fatality Reports accurately; however, the 30-Day Fatality Report was completed untimely. Home visits were made, and the family members were independently interviewed, and the case documentation of the interviews was thorough.

The allegation of FX was added and substantiated against the grandmother and parents. IG was substantiated against them. The Investigation Conclusion Narrative noted that a skeletal survey was completed on the child, and he was found to have healing fractures that could not have been a result of lifesaving measures. After learning of the injuries, the family was interviewed again, and they did not have an explanation. Therefore, the allegations were substantiated. DOA/Fatality was unsubstantiated, and the record reflected that the injuries were not likely the result of the death. Although the grandmother's partner had access to the child as he resided in the home, it remained unknown why allegations were not added against him.

MCDHS offered the family grief services, mental health referrals and burial assistance. The mother was previously engaged in therapy and continued attending. It remained unknown if the other adults utilized the referrals or whether burial assistance was utilized.

PIP Requirement

MCDHS will submit a PIP to the Rochester Regional Office within 30 days of the receipt of this report. The PIP will identify action(s) the MCDHS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, MCDHS 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:**
  - **Safety assessment due at the time of determination?** N/A

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:
Safety Assessments were not required as there were no surviving children.

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 30-day Fatality Report was completed untimely.

Required Actions Related to the Fatality

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

Issue:	The 30-Day Fatality Report is required to be completed in CONNECTIONS within 30 Days of receipt of a report alleging the death of a child as a result of abuse or maltreatment.
Summary:	The 30-Day Fatality Report was completed 8 days late.

Child Fatality Report

Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	MCDHS must document and approve a 30-Day Fatality Report within 30 days of receipt of a report alleging the death of a child resulting from abuse or maltreatment.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 01/27/2025 **Time of Death:** 08:42 AM

Time of fatal incident, if different than time of death: 08:00 AM

County where fatality incident occurred: Monroe
Was 911 or local emergency number called? Yes
Time of Call: 08:02 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: In bassinet

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	Grandparent	Alleged Perpetrator	Female	61 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	19 Year(s)
Deceased Child's Household	Other Adult - Grandmother's Partner	No Role	Male	44 Year(s)
Other Household 1	Father	Alleged Perpetrator	Male	18 Year(s)

LDSS Response

On 01/27/25, MCDHS received the fatality reports from the SCR. Within the first 24 hours of the investigation, MCDHS contacted the sources, documented a CPS history check, and notified the ME and DA's offices of the death.

On 01/27/25, the parents were interviewed at the hospital. The mother reported that she woke around 4:00 AM on the same day. She fed, burped and changed the child's diaper before placing him in his bassinet. Around 6:30 AM, she attended to the child again, and again around 8:00 AM. It was reported the child was placed to sleep on his back. After attending to the child, she left the room for approximately 20 minutes. When she returned, the child's eyes were fixed, he was cold to the touch and was unresponsive. She screamed and ran to the grandmother's room. They called 911. The mother used a suction device on the child and there was milk in his mouth. The mother performed rescue breaths until first responders arrived and took over resuscitation efforts. The mother reported placing the child to sleep with a blanket over his lower extremities and there was also a teddy bear on the sleeping surface. It remained unknown if anything was covering his face when the mother found him unresponsive. The father reported not being present at the time of the fatal incident, and that he did not have concerns for the care of the child.

The grandmother and her partner were interviewed separately. The grandmother reported the mother came into her room screaming that the child was not breathing. They called 911. The grandmother's partner was not present at the time of the fatal incident.

A hospital doctor provided information that upon arrival to the hospital, the child did not have a pulse, was cold to the touch and rigor mortis had not yet set in. There were no bruises observed on the child.

On 02/04/25, MCDHS learned a skeletal survey was conducted on the child and found multiple old, healing fractures. Law enforcement reported the fractures were not likely to have caused the death and that they were unable to consider the death a homicide.

On 02/26/25, MCDHS interviewed the family alongside law enforcement. The adults did not have concerns with anyone being rough with the child. The adults denied causing injuries to the child and reported the child did not ever fall or get dropped. At the time of case closure, it remained unknown how the child sustained the fractures.

MCDHS appropriately determined the allegation and closed the investigation timely on 03/12/25.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Unknown

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
Comments: The death was referred to a Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
070648 - Deceased Child, Male, 2 Month(s)	070649 - Mother, Female, 19 Year(s)	DOA / Fatality	Unsubstantiated
070648 - Deceased Child, Male, 2 Month(s)	070652 - Father, Male, 18 Year(s)	DOA / Fatality	Unsubstantiated
070648 - Deceased Child, Male, 2 Month(s)	070649 - Mother, Female, 19 Year(s)	Fractures	Substantiated
070648 - Deceased Child, Male, 2 Month(s)	070649 - Mother, Female, 19 Year(s)	Inadequate Guardianship	Substantiated
070648 - Deceased Child, Male, 2 Month(s)	070650 - Grandparent, Female, 61 Year(s)	Fractures	Substantiated
070648 - Deceased Child, Male, 2 Month(s)	070650 - Grandparent, Female, 61 Year(s)	Inadequate Guardianship	Substantiated
070648 - Deceased Child, Male, 2 Month(s)	070652 - Father, Male, 18 Year(s)	Fractures	Substantiated
070648 - Deceased Child, Male, 2 Month(s)	070652 - Father, Male, 18 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?	☐	☒	☐	☐

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 adults were offered bereavement services. The mother was engaged in counseling; it remained unknown if the other adults utilized the service. Burial assistance was offered; it remained unknown if it was used.

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

03/17/14- 09/03/14 The MGM was unsubstantiated for IG and SA of another child. Another adult was substantiated for the IG and SA of the other child.

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.

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