Office of Children and Family Services

Child Fatality Report

Report Identification Number: RO-25-017

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

Issue Date: Oct 15, 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: 1 year(s)
Jurisdiction: Yates
Gender: Male
Date of Death: 06/25/2025
Initial Date OCFS Notified: 06/25/2025

Presenting Information

An SCR report was received on 6/25/25, which stated the father took the one-year-old child to the basement to do laundry. The father secured the child in his car seat to prevent him from wandering around the basement. The child fell asleep in the car seat and was left in the basement for several hours. At approximately 5:20pm, the father found him unresponsive and cold to the touch. The father attempted to call 911 but did not have cellular service. The father sent a text message to the mother asking her to notify emergency services. The mother called 911 at 5:26pm. The father brought the child to the kitchen and performed cardiopulmonary resuscitation (CPR). Emergency medical services (EMS) transported the child to the hospital where he was pronounced deceased. The child was an otherwise healthy child, and the father did not have an explanation for his death.

Executive Summary

This report concerns the death of a 1-year-old male child. On 6/25/25, Yates County Department of Social Services (YCDSS) received an SCR report regarding the child's death. At the time of the child's death, he resided with his mother, father and two siblings, ages 2 and 3.

During the investigation, multiple contacts were made with the family and collateral contacts. It was learned that the father left the subject child unattended in an improperly buckled car seat in the basement of the home, for approximately four hours. When the father returned to check on the child he was observed to be unresponsive and partially hanging out of the car seat.

The medical examiner was notified and performed an autopsy of the subject child. The results of the autopsy were still pending at the close of the investigation. Preliminary results did not reveal a clear cause of death but did reveal bruising on the subject child's neck. At the close of the investigation, law enforcement was still investigating the incident and had not yet determined if criminal charges would be filed.

Due to a fair preponderance of evidence, the allegations of Inadequate Guardianship, Lack of Supervision and Inadequate Food, Clothing or Shelter against the mother and father, were substantiated. The investigation revealed that both parents had continuously left the children unsupervised for long periods of time, had allowed them to smear and eat feces, had allowed them to ingest paint chips from the walls, used corporal punishment and allowed them to reside in a deplorable home environment.

The allegation of DOA/Fatality against the father, regarding the subject child, was also substantiated. The death of the subject child was a direct result of the father leaving the child unattended, in an improperly secured car seat in the basement of the home, for over four hours.

PIP Requirement

This OCFS review resulted in citations. In response, YCDSS will submit a Program Improvement Plan (PIP) to the Regional Office, which will identify what action YCDSS has taken, or will take, to address the cited issues. For citations where a PIP is currently implemented, YCDSS will review the plan and revise them 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 investigation was appropriately determined.

Was the decision to close the case appropriate? N/A

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 the case circumstances. A Family Support Services case was opened for long-term services and support of the family.

Required Actions Related to the Fatality

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

Issue:	Timely/Adequate Case Recording/Progress Notes
Summary:	29 out of 76 progress notes were entered more than 30 days past their corresponding event date.
Legal Reference:	18 NYCRR 428.5
Action:	Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/25/2025 **Time of Death:** 06:46 PM

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

County where fatality incident occurred: Yates
Was 911 or local emergency number called? Yes
Time of Call: 05:26 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? No
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: 01
Adults: 00

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	1 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	25 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	21 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	03 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	02 Year(s)

LDSS Response

On 6/25/25, an SCR report was received regarding the death of a 1-year-old male subject child. YCDSS initiated their investigation immediately, spoke with the source of the report, coordinated with law enforcement and completed a CPS history review.

At approximately 11:30am, the subject mother left the home, leaving the subject child and the siblings in the care of the

father. At approximately 12:30pm, the father put the surviving siblings in their locked bedroom. He then placed the subject child in his 3-point-harness car seat, secured the top buckle, and carried it into the basement to do laundry. The subject child fell asleep, so the father went upstairs, did yard work outside, used his phone and took several naps before returning to the basement at approximately 5:20pm. He then found the child unresponsive and partially hanging from the car seat. He attempted to call 911 but was unable due to poor cellular service. He texted the mother and instructed her to call 911 while he attempted CPR. EMS responded and transported the subject child to the hospital where he was declared deceased at 6:46pm.

YCDSS conducted a home visit and observed piles of dirty diapers throughout the home that were accessible to the children. The sibling's bedroom contained only a mattress which was covered in feces, along with the walls, door and window of the room. The room also contained a locking mechanism on the inside and the outside of the door, preventing the children from leaving the room. The subject child's pack-n-play was also covered in feces, as well as the wall next to it. Law enforcement reviewed previous camera footage from the home that revealed the parents were continuously leaving the children unsupervised for extensive periods of time.

YCDSS received numerous phone calls and photos from concerned friends and relatives. The photos showed the children with injuries, bleeding lips and bruises. There were also photos of the children covered in their own feces, eating feces and paint chips and smearing feces.

As a result of the ongoing concerns, a neglect petition was filed against the mother and father. The surviving siblings were remanded and placed in the Article 1017 custody of their paternal grandmother. A Family Support Services case was opened for long-term support and services of the family.

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

Comments: The fatality was referred to the Ontario/Seneca/Yates region Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
072284 - Deceased Child, Male, 1 Year(s)	072286 - Father, Male, 25 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
072284 - Deceased Child, Male, 1 Year(s)	072285 - Mother, Female, 21 Year(s)	Lack of Supervision	Substantiated
072284 - Deceased Child, Male, 1 Year(s)	072285 - Mother, Female, 21 Year(s)	Inadequate Guardianship	Substantiated

072284 - Deceased Child, Male, 1 Year(s)	072285 - Mother, Female, 21 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
072284 - Deceased Child, Male, 1 Year(s)	072286 - Father, Male, 25 Year(s)	Lack of Supervision	Substantiated
072284 - Deceased Child, Male, 1 Year(s)	072286 - Father, Male, 25 Year(s)	DOA / Fatality	Substantiated
072284 - Deceased Child, Male, 1 Year(s)	072286 - Father, Male, 25 Year(s)	Inadequate Guardianship	Substantiated
072287 - Sibling, Female, 03 Year(s)	072286 - Father, Male, 25 Year(s)	Inadequate Guardianship	Substantiated
072287 - Sibling, Female, 03 Year(s)	072286 - Father, Male, 25 Year(s)	Lack of Supervision	Substantiated
072287 - Sibling, Female, 03 Year(s)	072285 - Mother, Female, 21 Year(s)	Lack of Supervision	Substantiated
072287 - Sibling, Female, 03 Year(s)	072285 - Mother, Female, 21 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
072287 - Sibling, Female, 03 Year(s)	072285 - Mother, Female, 21 Year(s)	Inadequate Guardianship	Substantiated
072287 - Sibling, Female, 03 Year(s)	072286 - Father, Male, 25 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
072288 - Sibling, Female, 02 Year(s)	072286 - Father, Male, 25 Year(s)	Lack of Supervision	Substantiated
072288 - Sibling, Female, 02 Year(s)	072285 - Mother, Female, 21 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
072288 - Sibling, Female, 02 Year(s)	072286 - Father, Male, 25 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
072288 - Sibling, Female, 02 Year(s)	072285 - Mother, Female, 21 Year(s)	Inadequate Guardianship	Substantiated
072288 - Sibling, Female, 02 Year(s)	072286 - Father, Male, 25 Year(s)	Inadequate Guardianship	Substantiated
072288 - Sibling, Female, 02 Year(s)	072285 - Mother, Female, 21 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?	☐	☒	☐	☐

Additional information:

29 out of 76 progress notes were entered more than 30 days past their corresponding event date.

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?	☒	☐	☐	☐
If Yes, court ordered?	☒	☐	☐	☐

Explain as necessary:
The surviving siblings were removed and placed in the Article 1017 custody of their paternal grandmother.

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?

☒Family Court ☐Criminal Court ☒Order of Protection

Family Court Petition Type: FCA Article 10 - CPS

Date Filed:	Fact Finding Description:	Disposition Description:
07/09/2025	There was not a fact finding	There was not a disposition

Respondent:	Mother Female 21 Year(s)
Comments:	An Article 10 neglect petition was filed on 7/9/25 and YCDSS requested the remand of the surviving siblings. The judge approved the remand and the siblings were placed in the 1017 custody of their paternal grandmother.

Have any Orders of Protection been issued? Yes

From: 07/09/2025	**To:** Unknown

Explain:
The surviving siblings were removed and placed in the Article 1017 custody of their paternal grandmother. The mother and father were granted supervised contact of the surviving siblings.

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:
A referral for grief counseling services was made. Day care assistance was also provided.

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:
Referrals were made for grief counseling services.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
02/07/2025	Sibling, Female, 2 Years	Father, Male, 25 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	No
	Sibling, Female, 2 Years	Father, Male, 25 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Sibling, Female, 2 Years	Father, Male, 25 Years	Swelling / Dislocations / Sprains	Unsubstantiated	
	Sibling, Female, 3 Years	Father, Male, 25 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Sibling, Female, 3 Years	Father, Male, 25 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Sibling, Female, 3 Years	Father, Male, 25 Years	Swelling / Dislocations / Sprains	Unsubstantiated	

Report Summary:
YCDSS received a report from the SCR alleging the father hit the siblings, ages 3 and 2, resulting in bruising and lacerations to their bodies. The 2-year-old sibling had swelling and bruising to her upper lip with no explanation.

Report Determination: Unfounded | **Date of Determination:** 03/07/2025

Basis for Determination:
Allegations from the report dated 2/7/25 were unfounded. The Investigation Conclusion Narrative stated there was not a fair preponderance of evidence to support the allegations. The father denied the use of physical discipline and no marks or bruises were observed on the children. The sibling was interviewed and denied any physical discipline was used in the home.

OCFS Review Results:
The investigation was initiated timely and a home visit was conducted promptly. Safety assessments and the RAP were completed timely and accurately. Collateral contacts were made appropriately.

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 was 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.

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