Office of Children and Family Services

Child Fatality Report

Report Identification Number: RO-25-019

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

Issue Date: Nov 14, 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 month(s)
Jurisdiction: Steuben
Gender: Female
Date of Death: 07/28/2025
Initial Date OCFS Notified: 07/28/2025

Presenting Information

An SCR report alleged, on 7/27/25, at 9:00PM, the mother and father placed the child between them in their bed to go to sleep. There were pillows and blankets around the child. The parents remained awake watching television. The child woke up at 11:00PM and was awake until 3:00AM. During that time the child was given a bottle and was laughing, kicking, and moving around. The child fell back to sleep between the parents in the bed at 3:00AM. The bottle was taken, and the parents also went to sleep around the same time. The parents woke up at about 10:40AM on 7/28/25. The child's cheek was cold to the touch and the child was purple in color. 911 was contacted while the grandmother and the father performed cardiopulmonary resuscitation (CPR) on the child. Law enforcement and emergency medical services (EMS) arrived at the home. The child was pronounced dead at the home at 11:50 a.m. It was alleged that the unsafe sleep conditions contributed to the child's death.

Executive Summary

This report concerns the death of the 4-month-old female subject child. Steuben County Department of Social Services (SCDSS) received an SCR report regarding the child's death on 7/28/25. At the time of the child's death, she resided with her mother, father, maternal grandmother, maternal uncle, and the grandmother's paramour. There were no siblings.

On 7/27/25, the parents had been out with the child for most of the day, attending a birthday party and a baby shower. They returned home around 7:30PM, at which point they changed and fed the child, and prepared food for themselves before going upstairs to their bedroom with the child around 8:30-9:00PM. The child was placed down for a nap on the parents' bed, and the parents went to the maternal uncle's room (which was unoccupied at the time as the uncle was at work) to smoke marijuana. The parents then returned to their room. The child woke around 10:30-11:00PM and remained awake until roughly 3:00AM. There were no concerns with the child between 11:00PM and 3:00AM. When the child fell back asleep, she was placed on the bed, "in her spot" between the mother and father. The parents would roll up a large blanket, and place it around the child, in a horseshoe shape, creating a sort of barrier. The child was placed in the middle of this rolled-up blanket, with her head slightly propped on the blanket. With the child asleep, the parents smoked marijuana again, then went to sleep themselves. When they next woke, about 10:40AM on 7/28/25, the child was ice cold to the touch, with discoloration to her chin and neck. The child was still within the confines of the blanket, and face-up. The mother screamed, ran downstairs with the child, and began CPR on the child with the child placed on the couch. 911 was called and EMS and law enforcement responded to the home. EMS took over CPR; however, rigor mortis had already set in, and it was clear on arrival that the child was already deceased. The coroner called the time of death as 11:50AM.

The medical examiner was notified and performed an autopsy on the child. The cause and manner of death were pending. Preliminary findings showed no injury to the child. Law enforcement's investigation remained open pending the final autopsy report, and law enforcement expressed belief the unsafe sleep conditions contributed to the child's death. No arrests had been made at the time the CPS investigation closed.

SCDSS made several home visits and interviewed all household members.

SCDSS made the appropriate determination to substantiate the allegations of Inadequate Guardianship and DOA/Fatality

against the parents regarding the death of the child. During the investigation, it was learned the parents regularly engaged in bedsharing with the child, in the manner described previously. The parents failed to exercise a minimum degree of care by bedsharing with aggravating factors present. At the time of the fatal incident, the parents had used marijuana twice (at 9:30PM and 3:00AM) and then placed the child in an unsafe sleep environment. The sleep environment's physical condition was unsafe in that the size (a full-sized bed) in relation to the occupants (two adults and the child), coupled with the contents (multiple heavy blankets and pillows), created an unsafe condition. As such, the investigation was indicated.

The family was offered and accepted bereavement services and funeral assistance.

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:
Following the fatality, there were no longer children in the household; therefore, safety assessments were not required.

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 was initiated, investigated, and determined timely. Appropriate services were offered to the family, and as there were no surviving siblings or other children residing in the household, there were no longer child welfare concerns that would warrant further CPS intervention. The case was determined appropriately with the evidence available at the time and closed.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 07/28/2025 **Time of Death:** 11:50 AM

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

County where fatality incident occurred: Steuben
Was 911 or local emergency number called? Yes
Time of Call: 10:44 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	20 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	4 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	23 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	42 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	22 Year(s)
Deceased Child's Household	Other Adult - MGM's paramour	No Role	Male	44 Year(s)

LDSS Response

On 7/28/25, SCDSS received an SCR report regarding the death of the subject child. SCDSS initiated their investigation within 24 hours and coordinated their efforts with law enforcement. SCDSS contacted the source of the report, completed a CPS history check regarding the family, and informed the DA of the fatality. SCDSS conducted an initial home visit the same day the report was received and learned there were no additional children in the home.

SCDSS interviewed all household members regarding the events leading up to the child's death. All adults provided

roughly similar accounts, and it was learned that the child had been consistently in the care of the parents throughout the day prior to the death (7/27/25) and in the overnight hours leading up to the death. The parents left the home with the child around noon on 7/27/25 to attend two parties and visit the mother's grandmother. They arrived back home around 7:30PM. The child was fed a bottle at that time, and after falling asleep, was placed on the parents' bed where she napped on and off. The child woke around 9:30-10:00PM, had a bottle, then fell back asleep. At that time, the parents left the room and smoked marijuana from a bong in the uncle's bedroom. The child then woke again and was up approximately from 11:00PM to 3:00AM. The parents were awake with the child. Once the child fell back asleep, the parents again left the room to smoke marijuana, before then falling asleep with the child between them within the horseshoe-shaped barrier made with a rolled-up blanket. The parents denied ever smoking in the same room as the child. The mother reported the child's pediatrician recommended the propping of the child's head due to spit up and that the doctor told them to "do whatever is needed" for them to get sleep, as the mother reported the child would scream if placed in the bassinet.

The initial home visit discovered the room shared by the parents and child to be concerningly unkempt. There were puppy pads with urine and feces on them, feces and vomit on the rug, laundry, multiple bottles of alcoholic beverages that were either empty, half full, or full, drug paraphernalia, garbage, a BB gun, and the dresser was piled with various items. The nightstands contained dirty dishes, drug paraphernalia, lighters, and other items, and on the floor, there was a bag full of "dabs" (marijuana). The bed contained multiple fleece/sherpa-type blankets, two pillows, a bottle, a pacifier, and burp cloths. Other areas of the home were found to contain marijuana and paraphernalia for its use. Both parents consented to a drug screen on 7/29/25, and both presented positive for marijuana. The parents denied drinking alcohol routinely, stating they last drank on 7/4/25. The bottles were kept in the room due to another household member's alcoholism.

SCDSS contacted numerous collateral sources. First responders commented on the obvious odor of marijuana in the home. On arrival, the child was observed receiving CPR from family members. EMS took over, and while receiving CPR, the child showed signs of rigor mortis, and mottling to the skin. It was estimated that the child had been deceased for over an hour prior to EMS arriving. The child was pronounced deceased in the home and did not go to the emergency room. The child's pediatrician reported the child attended all well-child visits and denied knowing of bedsharing, rather the parents stated the child slept in a bassinet. Medically, there were no concerns with the child.

Law enforcement reported no updates at the close of the CPS investigation. The autopsy report was still pending, with outstanding toxicology and other reports.

Bereavement services were offered and accepted by the family, though they were waitlisted and had not started services at the time the case closed. SCDSS provided funeral assistance as well.

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
072548 - Deceased Child, Female, 4 Month(s)	072550 - Father, Male, 23 Year(s)	DOA / Fatality	Substantiated
072548 - Deceased Child, Female, 4 Month(s)	072550 - Father, Male, 23 Year(s)	Inadequate Guardianship	Substantiated
072548 - Deceased Child, Female, 4 Month(s)	072549 - Mother, Female, 22 Year(s)	DOA / Fatality	Substantiated
072548 - Deceased Child, Female, 4 Month(s)	072549 - Mother, Female, 22 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	☐	☐	☐	☐	☐	☒

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 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