Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-25-006

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

Issue Date: Apr 28, 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: 5 month(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 01/13/2025
Initial Date OCFS Notified: 01/13/2025

Presenting Information

An SCR report was received on 1/13/25, which stated that the mother, father and 5-month-old child went to sleep in the same bed. When the mother woke up, the child was found at the side of the bed, in a water basin. It was unknown if the father was home when the mother woke up. The child was unresponsive, and the mother did not attempt to perform CPR. 911 was contacted, emergency medical services responded to the home and transported the child to the hospital. Medical staff at the hospital unsuccessfully attempted to resuscitate him and he was pronounced deceased at 12:14pm. The child had a small hematoma on his right frontal scalp and the parent's bed-sharing with the child may have contributed to his death.

Executive Summary

This report concerns the death of a 5-month-old male child. The New York City Administration for Children's Services (ACS) received an SCR report regarding the child's death on 1/13/25. At the time of the child's death, he resided with his mother, father and seven siblings, ages 15, 13, 11, 9, 6, 4 and 2.

On 1/13/25 at 7:00am, the subject mother got out of bed to get the surviving siblings ready for school, leaving the subject child in the center of her twin-sized bed. At approximately 11:10am, she went back into the bedroom and discovered the subject child had fallen out of the bed and was laying face down in a water basin next to the bed, that is used for a religious ritual. She attempted to resuscitate him by patting his back, but he did not regain consciousness. She then called her local Emergency Medical Services (EMS), who arrived within minutes. EMS attempted extensive life saving measures and transported the child to the hospital where he was pronounced deceased at 12:14pm.

There was not an autopsy performed due to a religious exemption, however the ME stated that he believed the child died from drowning in the water basin. He further stated that a child could drown in as little as an inch of water. When the child arrived to the hospital, he was observed with two small bruises on his leg and forehead, which the ME attributed to his fall from the bed. Law enforcement investigated the incident but did not pursue criminal charges.

The allegations of DOA/Fatality, Inadequate Guardianship and Lack Of Supervision were substantiated against the subject mother, for the subject child, due to a fair preponderance of evidence. During the investigation, ACS gathered information that the subject mother failed to provide the child with adequate guardianship and supervision by leaving him unattended in her bed, in an unsafe environment, for an extended period. As a result, the subject child fell off the bed and was found face down in the water basin next to the bed. Additionally, there were concerns that the subject mother had a pattern of bed-sharing with the child despite being aware of safe sleep practices.

The allegation of Inadequate Guardianship against the subject father was substantiated for the subject child based on a fair preponderance of evidence. During the investigation, ACS gathered information that revealed the mother regularly bed-shared with the subject child and the subject father was aware but took no action to intervene or stop the behavior.

The allegations of Lacerations, Bruises and Welts were unsubstantiated against the subject mother and the subject father, for the subject child. Although the child was observed with a bruise on his forehead and leg, upon examination, it was determined that the bruises were not inflicted on him.

The allegation of DOA/Fatality was unsubstantiated against the subject father, for the subject child. During the investigation, ACS learned that the subject father was not home at the time of the incident and was unaware that the subject mother left the child unsupervised that morning.

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

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:
A FSS case was created for ongoing support and services for the family.

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

Child Fatality Report

Date of Death: 01/13/2025 **Time of Death:** 12:14 PM

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

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 11:17 AM
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: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	5 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	37 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	37 Year(s)
Deceased Child's Household	Sibling	No Role	Male	15 Year(s)
Deceased Child's Household	Sibling	No Role	Male	13 Year(s)
Deceased Child's Household	Sibling	No Role	Male	11 Year(s)
Deceased Child's Household	Sibling	No Role	Male	9 Year(s)
Deceased Child's Household	Sibling	No Role	Male	6 Year(s)
Deceased Child's Household	Sibling	No Role	Male	4 Year(s)
Deceased Child's Household	Sibling	No Role	Male	2 Year(s)

LDSS Response

On 1/13/25, an SCR report was received regarding the death of a 5-month-old male child. ACS initiated their investigation within 24 hours, spoke with the source, notified the district attorney of the fatality, communicated with law enforcement and completed a CPS history review.

ACS completed a thorough investigation and met with all members of the family. The subject mother stated that the

morning of the incident, she fed the subject child in her bed, sometime between 5:30 and 6:30am. At 7:00am, she got up to get the surviving siblings ready for school, leaving the subject child in the center of her twin-sized bed. She stated after the siblings had left for school, she prayed, ate breakfast, spoke to a relative on the telephone and completed household chores. At approximately 11:00am, she went into her bedroom but did not see the subject child in the bed. She then discovered him face down in a water basin on the floor next to the bed. She picked him up and began patting him on the back while also calling EMS. She then brought him downstairs to his maternal grandparents' home to wait for EMS. EMS arrived within minutes and began extensive life saving measures. He was transported to the hospital where life saving measures continued but were unsuccessful. He was declared deceased at 12:14pm.

The subject father was interviewed and stated the morning of the incident, he left the home at 8:00am and did not have any interactions with the subject child before leaving that morning. The surviving siblings were also interviewed but none of them recalled seeing the subject child that morning before they left for school.

ACS completed a thorough home inspection. The home was observed to be safe with appropriate beds for the six oldest children and an appropriate crib for the 2-year-old child. A bassinet for the subject child was also observed at the initial home visit. The subject mother stated that she typically put the subject child to sleep at night in his basinet but moved him to her bed when he awoke for his next feeding. Multiple rectangular water basins, approximately 12 x 6 inches were observed in the home. The family stated each member of the family has their own basin to cleanse their hands before prayer each morning. The subject mother stated that the water is supposed to be dumped out after each use and the family is devastated that the water was accidentally left in hers the morning of the incident. Safe sleep practices and appropriate supervision were discussed with the parents. The siblings were accessed to be safe in the care of their parents throughout the investigation.

ACS appropriately spoke with collateral contacts including hospital staff, EMS, relatives, neighbors, school staff and the children's pediatrician. The children were up to date medically, attended school daily and there were no concerns for the care of the children expressed by anyone.

At the time the investigation was closed, a FSS case was open for ongoing support and counseling services for the family.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: Undetermined if injury or medical 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? No
Comments: The NYC region does not have an OCFS approved Child Fatality Review team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome

070577 - Deceased Child, Male, 5 Month(s)	070578 - Mother, Female, 37 Year(s)	Inadequate Guardianship	Substantiated
070577 - Deceased Child, Male, 5 Month(s)	070579 - Father, Male, 37 Year(s)	Inadequate Guardianship	Substantiated
070577 - Deceased Child, Male, 5 Month(s)	070578 - Mother, Female, 37 Year(s)	DOA / Fatality	Substantiated
070577 - Deceased Child, Male, 5 Month(s)	070578 - Mother, Female, 37 Year(s)	Lack of Supervision	Substantiated
070577 - Deceased Child, Male, 5 Month(s)	070578 - Mother, Female, 37 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated
070577 - Deceased Child, Male, 5 Month(s)	070579 - Father, Male, 37 Year(s)	Lacerations / Bruises / Welts	Unsubstantiated
070577 - Deceased Child, Male, 5 Month(s)	070579 - Father, Male, 37 Year(s)	DOA / Fatality	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	☒	☐	☐	☐

Explain:
The family is receiving preventive services including grief counseling and family counseling.

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	☐	☐	☐	☐	☐	☒

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:
The surviving siblings received grief counseling and family therapy.

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 parents received preventive services including family therapy, grief counseling and parenting education.

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

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