Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-25-035

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

Issue Date: Jul 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 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: 19 day(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 03/31/2025
Initial Date OCFS Notified: 03/31/2025

Presenting Information

An SCR report was received that alleged on March 31, 2025, at around 2:00AM, the 19-day-old male SC was being fussy while sleeping in his crib. The SM and SF moved the SC into their bed with them for the remainder of the evening. The SM and SF kept a water bucket on the floor next to the bed due to a religious belief. At around 7:00AM, the SM and SF found the SC pale and not breathing while face-first in the water bucket. The SM immediately contacted EMS. The SC was transported to the hospital at 7:30AM and was later pronounced deceased at 8:00AM.

Executive Summary

This fatality concerns the death of a 19-day-old male subject child which occurred while in the care of the subject mother and subject father. The New York City Administration for Children's Services (ACS) received an SCR report regarding the subject child's death on March 31, 2025. The SCR report contained allegations of DOA/Fatality and Inadequate Guardianship against the subject father and subject mother. At the time of his death, the subject child was residing with his parents. There were no surviving siblings.

On March 31, 2025, the subject father took the subject child out of his crib at 2:00AM and put the child in bed with him. They both fell asleep. Due to religious beliefs, the parents kept a hand-washing basin beside the bed. The subject parents woke up around 7:00AM and found the subject child unresponsive and prone against the wash basin face down. The maternal grandmother, who resided in the upper portion of the home, called 911 and began to administer CPR. When EMS arrived, they continued CPR until arriving at the hospital where hospital staff administered life-saving techniques for close to an hour, to no avail. The subject child was pronounced deceased at 8:03AM.

The medical examiner was notified and performed an external examination of the child. There were no signs of abuse. There was no autopsy or toxicology testing done based on the religious beliefs of the mother and father. ACS was told that there was not enough information to override the refusal of the autopsy with a judge and the body was released to the family. The medical examiner advised that it was important to make it clear that the death certificate would be noted as "undetermined" and the legal cause of death would also be listed as "undetermined" not "unknown". Additionally, the medical examiner noted that due to the small quantity of water found in the wash basin, the subject child likely died due to his head being turned in a certain way making the subject child unable to breathe properly causing his death. Law enforcement made no arrests and closed their investigation.

ACS made the appropriate determination to substantiate the allegations of DOA/Fatality and Inadequate Guardianship against the subject father as there was a fair preponderance of evidence to support an indicated determination. The subject father admitted to bed-sharing with the subject child causing him to fall out of the bed and subsequently landing on the wash basin, resulting in his death. Due to a lack of a fair preponderance of evidence, the decision to unsubstantiate the subject mother for the same allegations was appropriate. There was not a fair preponderance of credible evidence that the subject mother caused or contributed to the death of the subject child as she was sleeping when the fatal incident occurred, therefore unaware the father placed the child in the bed.

The parents declined bereavement services offered by ACS. At the time of the case closing, the parents were receiving counseling through their community and family.

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?** 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? 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 decision to close the case was appropriate.

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: 03/31/2025 **Time of Death:** 08:03 AM

Time of fatal incident, if different than time of death: 07:00 AM

County where fatality incident occurred: Kings

Was 911 or local emergency number called? Yes

Time of Call: 07:32 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	19 Day(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	20 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	21 Year(s)

LDSS Response

On March 31, 2025, ACS received a SCR report regarding the death of the 19-day-old SC. ACS initiated their investigation within 24 hours, completed a CPS history check which revealed no prior history, and coordinated their efforts with law enforcement. There were no surviving siblings.

On March 31, 2025, ACS interviewed the SF and SM. The SF and SM advised that on March 31, 2025, the SC was breastfed at 1:20AM. When the SC was finished with his feeding, the SM placed him in his crib in a supine position. The SM, SF, and the SC shared a bedroom. The parents slept in separate twin beds and the SC in his crib. The SC was still awake thirty minutes later. The SF took the SC out of his crib and played with him for a while. The SF stated that the SC was happy and not ready to go to sleep. The SF burped him a couple of times and then placed the SC in the bed with him. The SC was placed on his left side in the adult bed. Both the SF and SC fell asleep. The SF denied that he woke up again or that he turned over in his sleep. The SC was wearing a diaper, a shirt, and he was swaddled. The SF was unsure if the SC's arms were in the swaddle. The SM reported waking up around 7:00AM and looking for the SC in his crib before noticing him on the floor. The SC was unresponsive and pale lying against the plastic basin and a plastic cup of water that was kept beside the bed for religious purposes. The SF stated the plastic cup was half full and the wash basin was empty when he went to sleep. When they found the SC, he was face down against the basin and the cup. The SF stated the SC's body was outside the basin. Both parents denied that the SC's head was submerged in the little bit of water that fell out of the plastic cup, nor could they remember if he was dry.

The SM screamed for the MGM who resided upstairs in the home. The parents and the SC were staying in the basement apartment of the MGM's home through their religious holiday. The MGM ran downstairs picked up the SC and carried him upstairs before calling 911. She placed the SC on the couch and began to administer CPR, which continued until EMS arrived. When the paramedics arrived, the SC was apneic and asystole. They continued to administer CPR en route to the hospital. When they arrived at the hospital at 7:50AM, the SC's condition had not changed. Hospital staff continued to administer life-saving measures to no avail and the SC was pronounced deceased at 8:03AM.

ACS interviewed the MGM via phone on April 2, 2025 regarding the events leading up to the fatality. She stated the day before the fatality, everything was normal. She confirmed that on March 31, 2025, the SM called her frantically stating that something was wrong with the SC. She ran downstairs to find the SF holding the SC who was unresponsive. She confirmed that she grabbed the SC and called 911 before starting to administer CPR. She reported that the SC felt wet when she took him as he had fallen into the cup of water that was in the parent's bedroom. She denied that the SC slept in the parent's bed on a regular basis. She denied having any safety concerns regarding the care the parents provided to the SC. The MGM reported the parents were receiving therapy to help them deal with the death of the SC.

The medical examiner was notified and reported that there was no autopsy or toxicology screens completed due to religious objections from the family. LE reported that there were no criminal charges filed against the parents, and their investigation was closed.

Services were offered to the parents but declined. However, collateral sources reported that the family was engaged with counseling through their own community resources. The SF and SM confirmed knowledge and understanding of safe sleep practices.

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 New York City 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
071213 - Deceased Child, Male, 19 Day(s)	071215 - Father, Male, 20 Year(s)	Inadequate Guardianship	Substantiated
071213 - Deceased Child, Male, 19 Day(s)	071215 - Father, Male, 20 Year(s)	DOA / Fatality	Substantiated
071213 - Deceased Child, Male, 19 Day(s)	071214 - Mother, Female, 21 Year(s)	DOA / Fatality	Unsubstantiated
071213 - Deceased Child, Male, 19 Day(s)	071214 - Mother, Female, 21 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?	☒	☐	☐	☐

Additional information:

The maternal grandmother was interviewed by phone regarding the fatality and the actions she took to render aide to the subject child during the incident.

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 siblings or other children in the household at the time of and/or in response to the fatality? N/A
Explain:
There were no surviving siblings.

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 were offered bereavement services but declined. However, they were receiving counseling through their own community resources.

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 is 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