Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-25-037

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

Issue Date: Sep 23, 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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 3 month(s)
Jurisdiction: New York
Gender: Male
Date of Death: 04/06/2025
Initial Date OCFS Notified: 04/07/2025

Presenting Information

Multiple SCR reports were received on 4/6/25 that alleged that at approximately 10:00 PM, the mother put the subject child to sleep in the mother's bed. The subject child was placed face up using pillows as support. The mother took a shower and came back to find the subject child unresponsive. The subject child was visibly pale, not breathing, and had liquid coming from his mouth. At an unknown time, the mother called 911 and was coached in providing cardiopulmonary resuscitation on the subject child. Emergency medical services continued life-saving measures while transporting the child to the hospital at 10:37 PM. The hospital continued cardiopulmonary resuscitation and provided medication and fluids until the subject child was pronounced deceased at 11:07 PM. It was believed that the mother's unsafe sleep arrangement for the subject child contributed to his death. A subsequent report alleged the child's bottle was propped.

Executive Summary

This fatality report concerns the death of the 3-month-old male subject child that occurred on 4/6/25. The SCR report contained allegations of DOA/Fatality, Inadequate Guardianship, Lack of Supervision, and Choking/Shaking/Twisting against the mother. At the time of his death, the subject child resided with his mother and two surviving siblings, ages 9 and 5. The subject child’s father resided at a separate residence and had only visited the subject child four times. The father of the surviving siblings lived in a separate residence but regularly stayed at the mother’s residence to coparent.

The Administration for Children’s Services (ACS) completed casework and collateral contacts, and learned that on 4/6/25, the mother fed and burped the subject child, and placed him on her adult-sized bed to sleep. The mother placed a blanket up to the subject child’s chest and two pillows on each side of him. Around 10:05 PM, the mother went to take a shower. When the mother returned to the room approximately 5 minutes later, she observed the subject child to be unresponsive with clear white fluid coming from his mouth. The mother started doing chest compressions and contacted 911. The mother continued cardiopulmonary resuscitation until emergency medical services arrived and took over. The subject child was transported to the hospital, where he was pronounced deceased at 11:07 PM.

An autopsy was completed, and the final report was pending at the time of this writing. The subject child’s eyes, brain, and spinal cord were sent for further studies. The medical examiner stated preliminary findings would indicate sudden infant death. When ACS asked if the unsafe sleep environment could have been a factor, the medical examiner stated, “without a question.” The medical examiner stated that while the child was not bedsharing at the time of his death, he was on an adult bed, with a blanket, which were risk factors. The law enforcement case remained open pending the final autopsy report.

Bereavement services were offered to the family. The mother, siblings’ father, and surviving siblings were engaged in in-home therapy at the close of the CPS investigation. A preventive services case was initiated to assist the family with additional services. The allegations were appropriately determined. The CPS investigation was indicated and closed on 6/6/25.

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? 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:
Casework was commensurate with case circumstances.

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: 04/06/2025 **Time of Death:** 11:07 PM

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

County where fatality incident occurred: New York

Was 911 or local emergency number called? Yes

Time of Call: 10:15 PM
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	3 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	35 Year(s)
Deceased Child's Household	Sibling	No Role	Female	9 Year(s)
Deceased Child's Household	Sibling	No Role	Male	5 Month(s)
Other Household 1	Other Adult - SS's Father	No Role	Male	40 Year(s)
Other Household 2	Father	No Role	Male	33 Year(s)

LDSS Response

Upon receipt of the SCR report, ACS initiated their investigation within 24 hours, coordinated their efforts with LE, completed a CPS history review, conducted a home visit, interviewed all household members, and assessed the safety of the SSs.

ACS interviewed the SM and learned that on 4/6/25, the SM and 9yo SS went to do laundry, while SS's BF stayed at the home with the 5yo SS and SC. The SM returned home around 4:00 PM and fed the SC. The SC then slept from 6:00 to 9:00 PM. The SM fed the SC at 9:40 PM and laid him face-up on her adult-sized bed with two pillows on each side of him. The SM put a blanket on the SC, but stated his face was uncovered. Around 10:05 PM, the SM went to take a shower and returned around 10:10 PM. The SM noticed the SC had fluid coming out of his mouth and was unresponsive. The SM called 911, and EMS responded to the home. Life-saving measures were performed, and the SC was transported to the hospital, where he was later pronounced deceased.

The SSs were forensically interviewed and reported being asleep at the time of the incident, and being awoken by the SM screaming. Both SSs reported that the SC slept in the SM's bed and did not sleep anywhere else. The SS's BF was at work at the time of the incident and did not have further information.

ACS observed a portable crib folded up in the corner of the home. When asked about the crib, the SM stated she had folded it up the previous week and admitted to bedsharing since then. The SM gave multiple explanations as to why the SC

was not sleeping in the crib. The SM stated the crib took up too much space, she felt safer with the SC close to her, she thought the SC was more comfortable on her bed, and that the SC would not sleep through the night in the crib. Pediatric records indicate safe sleep guidelines were discussed with the SM at appointments, and the SM confirmed she was aware of safe sleep guidelines. In 2015, the SM had a 2-month-old child die while in an unsafe sleeping environment. That child's cause of death was undetermined, though it was noted that the child was swaddled and put to sleep on his stomach. At that time, the SM confirmed she was aware of safe sleep guidelines.

The SC was born premature at 35 weeks gestation and spent time in the Neonatal Intensive Care Unit (NICU). The SC was up to date medically; however, pediatric records indicated the SC had an elongated skull that required further imaging. ACS discussed this with their medical consultant; however, the findings of this were not reflected in the record.

Services were offered and accepted by the family. The SSs were deemed safe in the care of the SM and their BF.

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? No
Comments: There is no Child Fatality Review Team in the New York City Region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
072028 - Deceased Child, Male, 3 Month(s)	072117 - Mother, Female, 35 Year(s)	DOA / Fatality	Substantiated
072028 - Deceased Child, Male, 3 Month(s)	072117 - Mother, Female, 35 Year(s)	Inadequate Guardianship	Substantiated
072028 - Deceased Child, Male, 3 Month(s)	072117 - Mother, Female, 35 Year(s)	Choking / Twisting / Shaking	Unsubstantiated
072028 - Deceased Child, Male, 3 Month(s)	072117 - Mother, Female, 35 Year(s)	Lack of Supervision	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?	☐	☒	☐	☐
Emergency Room Personnel	☐	☒	☐	☐
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:

ACS attempted to contact hospital staff and EMS; however, their attempts were unsuccessful.

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?	☐	☒	☐	☐

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	☐	☐	☐	☐	☐	☒

Additional information, if necessary:
The SM and SS's BF were requested to take a drug screen and complete a substance/alcohol evaluation, but declined. The SM admitted to smoking marijuana; however, not in the presence of the children. The SS's BF denied substance use. A preventive case was opened to assist the family with services. The family was receiving in-home therapy.

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

12/19/14 IG was substantiated against the SM regarding the then newborn sibling. The SM used marijuana while pregnant, and the child tested positive for marijuana at the time of birth. Allegations of IF/C/S were unsubstantiated.

2/22/15 and 2/24/15 IG and FX were substantiated against the SM as the then 2-month-old sibling died in an unsafe sleeping environment. The child was swaddled and placed on his stomach on an adult bed. The SM was aware of safe sleep guidelines. It was discovered that the child had a fractured femur that was determined to be inflicted; however, no caregivers were able to provide an explanation. The child's cause of death was undetermined. The allegation of DOA was unsubstantiated.

2/1/18 IG, LS, and PD/AM were substantiated against the SM regarding the now 9yo SS and a child that has since been adopted. The SM tested positive for marijuana after giving birth to the now adopted child and admitted to using marijuana while pregnant. The now adopted child was placed in care, where she remained until her adoption. The now 9yo SS was remanded to her father at that time.

4/10/19 IG and PD/AM were substantiated against the SM regarding the now 5yo SS due to the SM smoking marijuana during pregnancy and testing positive at the time of birth. An Article 10 Neglect Petition was filed on 4/17/19 against the SM. On 4/19/19 the 5yo was released to the SM on the condition that the SM comply with services. The SM entered an inpatient program with the now 5yo SS.

Known CPS History Outside of NYS

There was no known CPS history outside of New York State.

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