Child Fatality Report

Report Identification Number: NY-25-040

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

Issue Date: Jul 07, 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: Queens
Gender: Male
Date of Death: 04/16/2025
Initial Date OCFS Notified: 04/17/2025

Presenting Information

An SCR report received on 4/16/25 alleged that morning, the father was sleeping in bed with the subject child. The father woke up at an unknown time and discovered the child was face-down on the side of the bed, in between the wall and the bedframe. The child was not breathing at the time. The father called 911 and emergency medical services responded to the home. Emergency medical services performed cardiopulmonary resuscitation and transported the child to the hospital. At the time of the initial report, the child was hospitalized and in critical condition. The child's condition was alleged to be a result of an unsafe sleep situation. A second report alleged the father rolled over the child. Two additional reports were received on 4/17/25, following the child's death.

Executive Summary

This report concerns the death of the 5-month-old male subject child. The Administration for Children's Services (ACS) received multiple SCR reports regarding the fatal incident and subsequent death of the child on 4/16/25 and 4/17/25. At the time of the child's death, he resided with his mother, father, sibling, and maternal grandparents.

On 4/16/25, the child woke around 3:00AM. The child was in bed with the parents and had been sleeping in the middle, between both parents. The family had begun the practice of bedsharing with the child about a week prior. The child was playful when he woke and played in bed between the parents until around 4:00AM, at which time the father fed the child a bottle. The child was irritable from teething and the mother remained awake with the child until the child eventually fell back asleep. Around 5:10AM, the mother got out of bed and went downstairs to the grandparents' apartment, where the sibling was staying. The mother did not return upstairs prior to leaving for work at 6:30AM. The father next woke around 7:00AM, and not feeling the child in his arms, the father "sprang out" of bed. He could not immediately find the child. Thinking the mother might have brought the child downstairs with her, he checked downstairs, but the child was not there. Panicked, the father looked around the bedroom again and found the child on the bed, in the space between the mattress and the wall, face-down on top of rolled-up blankets that had been used to fill the gap of space between the mattress and wall. The father picked-up the child and ran downstairs to the grandparents' apartment, 911 was called, and the visiting aunt began cardiopulmonary resuscitation (CPR). Emergency medical services (EMS) arrived and took over life-saving efforts and transported the child to the hospital. The child was stabilized and transported in critical condition to a second hospital for a higher level of care and placed on life-support. The child had suffered severe hypoxic respiratory failure, hemodynamic instability, severe neurological injury with likely injury to other organs and had a very poor prognosis. The child was pronounced deceased later that day, at 6:31PM.

The medical examiner was notified and performed an autopsy on the child. The cause and manner of death were pending at the time the CPS investigation was closed due to outstanding testing. The medical examiner reported no internal injuries, and when asked, stated the sleep environment could have caused or contributed to the death. A re-enactment was completed, and pictures were shared with ACS, which depicted how the child was placed to sleep and how the child was later found. Law enforcement investigated and closed without arrest.

ACS made several home visits and interviewed the mother, father, and relevant family members. The sibling was assessed safe and remained in the parents' care.

ACS made the appropriate determination to substantiate both Inadequate Guardianship and DOA/Fatality against the parents. There was joint admittance to engaging in bedsharing on a regular basis, besides just on the night of the fatality. While the mother was not present in the home when the child was found unresponsive, the mother did knowingly leave the child in the unsafe sleep environment when she left the home while the father was asleep and bedsharing with the child. ACS appropriately downgraded the allegation of DOA/Fatality to maltreatment, as the death was related to unsafe sleep. The medical examiner reported no internal injuries, and the corresponding allegation was appropriately unsubstantiated.

Services were offered the family and the sibling engaged in play therapy. Preventive services were declined.

PIP Requirement

ACS will submit a PIP to the New York City Regional Office within 45 days of the receipt of this report. The PIP will identify action(s) the ACS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ACS will review the plan and revise 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:

Casework activities were sufficient; however, there was an error in scoring the Risk Assessment Profile.

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:
While not required, it would have been prudent for ACS to merge the two initial investigations regarding the fatal incident, rather than maintain separate records, which leads to a duplication of allegation determinations and unnecessary casework activity.

Required Actions Related to the Fatality

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

Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	The RAP was not scored to reflect the elevated risk element of 'death of a child as a result of abuse or maltreatment by caretakers' despite DOA/Fatality being substantiated against both parents regarding the death of the child.
Legal Reference:	18 NYCRR 432.2(d)
Action:	ACS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 04/16/2025 **Time of Death:** 06:31 PM

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

County where fatality incident occurred: Queens
Was 911 or local emergency number called? Yes
Time of Call: 06:59 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	5 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	32 Year(s)
Deceased Child's Household	Grandparent	No Role	Male	60 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	58 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)
Deceased Child's Household	Sibling	No Role	Female	3 Year(s)

LDSS Response

On 4/16/25, ACS received two reports regarding the fatal incident, and on 4/17/25, received two additional reports regarding the death of the subject child. ACS initiated their investigation within 24 hours and coordinated their efforts with law enforcement. ACS contacted the sources of the reports, completed a CPS history check regarding the family, which revealed no prior child welfare history, and informed the DA of the fatality. ACS assessed the safety of the sibling and conducted multiple home visits throughout the investigation.

ACS interviewed all adults regarding the events leading up to the child's death. A timeline was provided by the parents. The father reported that on 4/15/25, the child went to sleep around 11:00PM, waking at 1:00AM and 3:00AM. Despite having a crib available, the parents began bedsharing with the child about a week ago. The shared mattress was placed against the wall, and the mother would sleep on the side closest the wall, the child in the middle, and the father on the far side. There was an approximate 10-inch gap between the mattress and wall that had been stuffed with blankets. After feeding the child a bottle at approximately 4:00AM, the child fell back asleep, cradled in the father's left arm, in the center of the bed. The father fell back asleep, and the mother got up and out of bed at 5:10AM to get ready for work and went downstairs. The maternal grandparents resided downstairs, which was where the sibling was sleeping. The mother relieved the grandmother, who left for work at 5:30AM. The grandfather returned from work at 6:20AM, relieving the mother, who then left for work at 6:30AM. The father remained asleep upstairs with the child. The father woke around 7:00AM and did not feel the child in his arms. After frantically looking around the home for the child, the father found the child face-down on the blankets rolled between the mattress and wall. The father picked up the unresponsive child and brought him downstairs to the grandparents' apartment. An aunt who was downstairs at the time heard the father screaming and saw the father on the floor, distraught, and the child had blood coming out of his nose. The aunt, who was CPR certified, initiated CPR and called 911, then called the mother. EMS and the mother arrived at the home shortly after 7:00AM. EMS took over CPR and the child was transported to the hospital.

ACS obtained photos from the ME taken during a re-enactment and asked the ME about the sleep environment in relation to the death. The ME reported the sleep environment could have caused or contributed to the death. The child had a reported cardiac condition, and further testing was needed to see if that was related to the child's death. ACS contacted the child's cardiologist who saw the child on 11/28/24 and 2/12/25, and ultimately discharged the child from the practice as he did not have any life-threatening condition and an electrocardiogram was normal, no heart murmur was detected, and the child did not have any congenital disease. ACS learned the mother and sibling had cardiac conditions as well, which were well-managed.

Services were offered to the family, and they accepted bereavement referrals; however, waitlists were long. PPRS were offered and ultimately declined. The sibling's school assisted with counseling services for the sibling. At the close of the investigation, the sibling was assessed safe, and no criminal charges were brought against either parent in relation to the death. ACS did find a fair preponderance of evidence to support indicating the investigation.

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 OCFS approved Child Fatality Review Team in the NYC region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
071471 - Deceased Child, Male, 5 Month(s)	071473 - Father, Male, 32 Year(s)	Internal Injuries	Unsubstantiated
071471 - Deceased Child, Male, 5 Month(s)	071473 - Father, Male, 32 Year(s)	DOA / Fatality	Substantiated
071471 - Deceased Child, Male, 5 Month(s)	071473 - Father, Male, 32 Year(s)	Inadequate Guardianship	Substantiated
071471 - Deceased Child, Male, 5 Month(s)	071472 - Mother, Female, 30 Year(s)	DOA / Fatality	Substantiated
071471 - Deceased Child, Male, 5 Month(s)	071472 - Mother, Female, 30 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?	☒	☐	☐	☐
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:
While bereavement services were offered, there was a waitlist for the adults to engage in services. As such, PPRS was offered and while the family initially accepted, they ultimately declined preventive services as the sibling had been engaged with fatality-related services through her school and that was their main priority. It was unknown if the family utilized offered funeral assistance.

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 sibling received play therapy and social work services in response to the fatality.

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 family expressed an interest in bereavement services and appropriate referrals were made; however, long waitlists created barriers for the family.

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