Child Fatality Report

Report Identification Number: NY-25-050

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

Issue Date: Sep 15, 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: 5 month(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 05/19/2025
Initial Date OCFS Notified: 05/19/2025

Presenting Information

An SCR report alleged that on 5/19/25, the father was the sole caretaker of the child. The father checked on the child around 4:00AM and found her asleep in the Pack 'N Play. The mother returned from work at 5:00AM and found the child blue and unresponsive, lying face down in the Pack 'N Play. The mother called 911, and on arrival law enforcement used a device to analyze the child's heart rhythm and began CPR. The child was transported to the hospital where she was pronounced deceased at 6:34AM. The subject child was otherwise healthy, and the father had no explanation for her death.

Executive Summary

This report concerns the death of the 5-month-old female child that occurred on 5/19/25. The Administration for Children's Services (ACS) received an SCR report which contained allegations of DOA/Fatality and Inadequate Guardianship against the father. At the time of the child's death, she resided with her mother, father, and three adult maternal uncles.

At 4:00AM on 5/19/25, the father fed the child and placed her on her back to sleep on the adult bed they regularly shared. At 5:00AM, the mother returned home from work and found the child face down on the bed. The child was pale in color, slightly warm, and had blood around her nose. The mother alerted the father and began mouth to mouth while the father called 911. On arrival, Emergency Medical Services (EMS) took over life-saving measures and transported the child to the hospital where she was pronounced deceased.

The medical examiner was alerted, and an autopsy was performed. The cause and manner of death were pending the final autopsy report. Law enforcement was notified and began an investigation. When the CPS investigation closed, law enforcement had not made any arrests and the criminal investigation remained open, pending the final autopsy report.

ACS added allegations of Inadequate Guardianship against the mother, and Parent's Drug and Alcohol Misuse against the father after additional information was obtained during the investigation. ACS appropriately substantiated all allegations. Bereavement referrals and burial assistance was offered to the family. The case was closed timely on 7/17/25.

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:
The case record demonstrated ACS obtained a fair preponderance of evidence to substantiate all allegations. The case was appropriately indicated and closed.

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 activity was commensurate with case circumstances. The case record showed ACS did not contact the pediatrician despite obtaining a signed HIPAA release; however, medical documentation was obtained from the family that demonstrated the child saw a pediatrician and was up-to-date medically.

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: 05/19/2025 **Time of Death:** 06:34 AM

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: 05:07 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	30 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Male	29 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Male	27 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	5 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	34 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	33 Year(s)

LDSS Response

On 5/19/25, ACS received an SCR report regarding the death of the child. ACS initiated their investigation within 24 hours, coordinated efforts with law enforcement, contacted the source of the report, completed a CPS history check regarding the family, informed the DA of the fatality, and interviewed the caregivers. There were no surviving siblings.

ACS interviewed the father, who had been admitted to the hospital shortly after his arrival, with the assistance of an interpreter. The father stated the child was asleep when he returned home from work at 10:00PM and the child woke twice between his arrival and 3:00AM, drinking half a bottle both times. The father stated the baby was last seen alive around 4:00AM, and he was awakened by the mother telling him the child was not breathing. He did not know what position the child was found in as the mother was holding her; however, the father stated he put her to sleep on her back. The father stated the child was not under him, so he could not have rolled on top of her. The father stated the child was a normal color and he did not observe anything coming from her nose or mouth. The father admitted to drinking approximately 60oz of alcohol prior to the incident, which he regretted, acknowledging that it may have affected what happened to him and the care provided to the child. He stated he was intoxicated the day of the incident; however, not when he arrived at the hospital. The father was unable to explain why he was admitted to the hospital, and stated he was injected with something. The father lost his temper when hospital staff told him he could not hold the child.

The mother was interviewed with the assistance of an interpreter. The mother stated she was at work the night of the fatal incident. She video called the father at 3:20AM, and the child was observed smiling and laughing. The mother had no concerns during the call and saw the father had made a bottle for the child. Upon her return home, she found the child face down on the bed and not breathing. The mother stated the child was pale in color, warm, and had blood around her nose. The mother woke the father and attempted mouth to mouth while the father called 911.

The mother and father stated they were educated on safe sleep practices when the child was born. They stated they had a bassinet; however, the child did not like sleeping in it and would cry, so they got rid of it because it was taking up space.

Hospital staff stated the child arrived in cardiac arrest and despite life-saving efforts, she was pronounced deceased. Hospital staff reported the father arrived at the hospital intoxicated and began acting erratically. He became aggressive and

interfered with medical staff and staff attempted to intervene; however, he had to be restrained and sedated when he began banging his head. An assessment was completed regarding substance use, which he denied was a problem, and he was provided information regarding mental health services before being discharged.

ACS attempted to interview the uncles who resided in the home; however, information provided regarding the night of the fatal incident was sparse. Two of the uncles stated they were not present for the event as they were in their bedrooms. They were evasive with answers and did not provide ACS with contact details for further questioning. One of the maternal uncles did not make himself available for ACS to interview.

ACS contacted several collaterals, including neighbors, hospital staff, law enforcement, and the medical examiner; there were no concerns shared. Referrals were offered to the mother and father, and the case was indicated and closed as there were no other identified needs or surviving siblings.

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
071708 - Deceased Child, Female, 5 Month(s)	071709 - Father, Male, 34 Year(s)	DOA / Fatality	Substantiated
071708 - Deceased Child, Female, 5 Month(s)	071709 - Father, Male, 34 Year(s)	Inadequate Guardianship	Substantiated
071708 - Deceased Child, Female, 5 Month(s)	071709 - Father, Male, 34 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
071708 - Deceased Child, Female, 5 Month(s)	071710 - Mother, Female, 33 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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
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	☐	☐	☐	☐	☐	☒

Additional information, if necessary:
ACS offered the family appropriate referrals 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:
Services were offered to the mother and father in response to the fatality.

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
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs
- ☐ Used prescription drugs

☐ Used marijuana

☒ Was not noted in the case record to have any of the issues listed

Infant was born:

☐ With a positive toxicology

☐ With fetal alcohol effects or syndrome

☐ Exhibiting withdrawal symptoms

☒ 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