Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-25-057

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

Issue Date: Nov 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 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		

Case Information

Report Type: Child Deceased
Age: 12 year(s)
Jurisdiction: Queens
Gender: Female
Date of Death: 06/06/2025
Initial Date OCFS Notified: 06/06/2025

Presenting Information

An SCR report alleged that on 06/06/25, the unrelated home member and the child went to sleep in the same bed. At an unknown time, the unrelated home member woke up and observed the child to be face-up and not breathing. She called 911 at 7:43 PM. EMS arrived at the home, performed CPR and transported the child to the hospital. Hospital staff continued resuscitation efforts to no avail and the child was pronounced deceased. The unrelated home member did not have an explanation for the death.

Executive Summary

This report concerns the death of the 12-year-old child that occurred on 06/06/25. A report was made to the SCR on the same day with allegations that the child was in the care of the unrelated home member when they both went to sleep. Later, the unrelated home member discovered the child was not breathing. The child subsequently died. At the time of her death, the child resided with the parent and the unrelated home member. There were no siblings or other children.

The Administration for Children's Services (ACS) coordinated investigative efforts with law enforcement upon receipt of the report. The adults were arrested regarding criminal possession of controlled substances, and criminal possession of a weapon. An autopsy was performed. The cause of death was acute intoxication by the combined effects of fentanyl and heroin. The manner of death was undetermined.

ACS interviewed the parent and unrelated home member. They reported that the child acted normally in the days prior to her death. The unrelated home member watched a movie with the child and then they went to sleep. Later, she found the child was not breathing and contacted the parent. The child was transported to the hospital where she was pronounced deceased.

The parent was not present at the time of the fatal incident. The parent reported seeing the child on FaceTime prior to the death, and they made plans to get their hair and nails done.

During the investigation, it was revealed that the parent and unrelated home member would provide the child with marijuana and allowed her to use it. The record did not reflect the last time the child was provided with or used marijuana.

The medical examiner's office later reported that the child tested positive for heroin and fentanyl, causing law enforcement to obtain a search warrant for the home. Law enforcement officers located illicit drugs and weapons in the home. The adults were arrested, and the criminal charges remained pending.

ACS contacted collaterals including school staff, a friend and the father. The father did not have a relationship with the child. The friend said the child was healthy in the days prior to her death. The friend was with the parent when the unrelated home member contacted the parent to alert her to the child's condition. The friend stated that she and the parent called 911. School staff and the friend shared that the parent and unrelated home member provided the child with marijuana.

ACS offered the adults funeral assistance and bereavement services. Funeral assistance was provided to the family by

another entity. It remained unknown if they utilized the bereavement services referral.

The record did not reflect the father was provided with written notice of the SCR report or Notice of Indication. The record contained information that was not factual as the parent had multiple names and personal identification numbers in Connections. The profiles were not merged and therefore, it appeared that the parent was different people.

ACS substantiated Inadequate Guardianship, Parent Drug/Alcohol Misuse and DOA/Fatality. The Investigation Conclusion Narrative reflected that the home had drugs and weapons accessible to the child. Although illicit drugs were found in the home, and a progress note regarding a prior investigation stated the unrelated home member had previously stated that she used drugs, the record did not reflect that either adult was under the influence of drugs or alcohol while caring for the child. The record did not reflect adding the allegation of Child's Drug/Alcohol Use was considered. ACS closed the investigation timely on 08/04/25.

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:**
  - **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:
Safety Assessments were not required as there were no surviving siblings.

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
Notice of Indication was not provided to the father. The allegation of CD/A was not documented to have been considered. The record contained contradictory information regarding the parent.

Required Actions Related to the Fatality

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

Issue:	Failure to Provide Notice of Indication
Summary:	The record did not reflect the father was provided with Notice of Indication.
Legal Reference:	18 NYCRR 432.2(f)(3)(xi)
Action:	Within 60 days, whether a report assigned to the investigative track is "indicated" or "unfounded", and if "indicated", ACS must deliver or mail to the subject(s) and other persons named in the report, except children under the age of 18 years, a written notification, within 7 days of the determination, in such form as required by OCFS.

Issue:	Case record contains information that is relevant, useful, factual and objective
Summary:	The parent had a different name, personal identification number and client identification number historically. The individual's profiles were not merged, making it appear they were separate people.
Legal Reference:	18 NYCRR 428.1(a) and 18 NYCRR 428.1(b)(1)
Action:	ACS records must contain information that is relevant, useful, factual and objective to best reflect accuracy throughout documentation. Such information is pertinent to investigations and the review of service needs.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/06/2025 **Time of Death:** 09:04 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: 07:43 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? Yes
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	Female	12 Year(s)
Deceased Child's Household	Other - Parent	Alleged Perpetrator	Male	35 Year(s)
Deceased Child's Household	Unrelated Home Member	Alleged Perpetrator	Female	65 Year(s)

LDSS Response

On 06/06/25, ACS received the report from the SCR. Within the first 24 hours of the investigation, ACS contacted the source of the report, documented a CPS history check, coordinated investigative efforts with law enforcement and notified the DA and ME's offices of the report.

On 06/06/25, ACS interviewed the unrelated home member. She reported that in the days prior to the death, the child acted normally. She reported the child did not have any known medical conditions. The unrelated home member reported that on the day of the death, she and the child slept in the same bed. When the unrelated home member got up to use the bathroom, she noticed that the child had mucus coming out of her nose and mouth. The child was not breathing. The unrelated home member was unable to wake the child and blew into her mouth. She contacted the parent who called 911.

The parent was interviewed and reported talking to the child on 06/06/25 and that the child was fine. The parent reported that the unrelated home member discovered the child unresponsive. The parent was not home at the time of the fatal incident. The parent reported a doctor said the child died of a pulmonary embolism. It remained unknown where this information was ascertained.

Initially, the child's toxicology report was negative; however, further testing was performed and revealed that the child had marijuana, fentanyl and heroin in her system. Law enforcement obtained a search warrant and seized illicit substances and weapons from the home. The adults were arrested on various drug and weapon charges. It remained unknown if the adults provided the child with the illicit drugs, or if the child took the drugs on her own. At the time of determination, the adults remained incarcerated. Prior to the death, the adults reported providing the child with marijuana on more than one occasion and would allow her to smoke the marijuana in their presence.

Following the arrests, ACS determined the allegations and closed the investigation timely.

Official Manner and Cause of Death

Official Manner: Undetermined

Primary Cause of Death: From an injury - external cause

Person Declaring Official Manner and Cause of Death: Other physician

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? Yes

Comments: It remained unknown if the case was referred to an OCFS-approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
072415 - Deceased Child, Female, 12 Year(s)	072416 - Other - Parent, Male, 35 Year(s)	DOA / Fatality	Substantiated
072415 - Deceased Child, Female, 12 Year(s)	072416 - Other - Parent, Male, 35 Year(s)	Inadequate Guardianship	Substantiated
072415 - Deceased Child, Female, 12 Year(s)	072416 - Other - Parent, Male, 35 Year(s)	Parents Drug / Alcohol Misuse	Substantiated
072415 - Deceased Child, Female, 12 Year(s)	072417 - Unrelated Home Member, Female, 65 Year(s)	DOA / Fatality	Substantiated
072415 - Deceased Child, Female, 12 Year(s)	072417 - Unrelated Home Member, Female, 65 Year(s)	Inadequate Guardianship	Substantiated
072415 - Deceased Child, Female, 12 Year(s)	072417 - Unrelated Home Member, Female, 65 Year(s)	Parents Drug / Alcohol Misuse	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?	☐	☒	☐	☐

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?

☐Family Court ☒Criminal Court ☐Order of Protection

Criminal Charge: Other - Criminal possession of a controlled substance **Degree:** 3

Date Charges Filed:	Against Whom?	Date of Disposition:	Disposition:
Unknown	The parent and unrelated home member	Pending	Pending
Comments:	The parent and unrelated home member were charged with criminal possession of a controlled substance in the 3rd degree, and 2 counts of criminal possession of a controlled substance in the 7th degree.		

Criminal Charge: Other - Criminal possession of a weapon **Degree:** 2

Date Charges Filed:	Against Whom?	Date of Disposition:	Disposition:
Unknown	The parent and unrelated home member	Pending	Pending
Comments:	The parent and unrelated home member were charged with criminal possession of a weapon in the 2nd degree (an armed felon), criminal possession of a firearm, criminal possession of a weapon in the 4th degree and firearms, unlawful possession of a pistol, revolver and ammunition.		

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 parent(s) and other care givers at the time of and/or in response to the fatality? Yes

Explain:

The parent and the unrelated home member were offered bereavement services, mental health referrals and burial assistance. The parent declined funeral assistance. It remained unknown if the adults utilized the counseling referrals.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes

Was the child acutely ill during the two weeks before death? No

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)

01/21/2025	Deceased Child, Female, 12 Years	Other - Parent, Male, 34 Years	Inadequate Guardianship	Unsubstantiated	No
	Deceased Child, Female, 12 Years	Other - Parent, Male, 34 Years	Lacerations / Bruises / Welts	Unsubstantiated	

Report Summary:
An SCR report alleged the parent had a history of being physically aggressive toward the child. On 01/21/25, the parent argued with the child about getting ready for school. The parent struck the child in the face with a closed fist. As a result, the child sustained a swollen lip. The parent pushed the child in the shower and shattered the shower door. It remained unknown if the child sustained physical injuries.

Report Determination: Unfounded | **Date of Determination:** 02/19/2025

Basis for Determination:
The Investigation Conclusion Narrative indicated that the parent and child got into an altercation. They argued as the child was not attending school and was not listening. There was no evidence to substantiate the allegations.

OCFS Review Results:
The investigation was initiated timely, and the source was contacted. Home visits were made, and a CPS history check was documented. Appropriate collateral contacts were made.

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

[redacted]

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
01/08/2025	Deceased Child, Female, 11 Years	Other, Male, 34 Years	Inadequate Food / Clothing / Shelter	Far-Closed	No

Report Summary:
An SCR report alleged the home in which the parent and child resided was filthy and a safety hazard. There was trash strewn about. There were holes in the doors and walls.

OCFS Review Results:
The case was tracked FAR, and the Safety Assessments were completed accurately. The FLAG was completed timely. Notification of FAR was provided.

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

[redacted]

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
06/21/2024	Deceased Child, Female, 10 Years	Other - Parent, Male, 34 Years	Inadequate Guardianship	Unsubstantiated	No

Report Summary:
An SCR report alleged that on 06/20/24, the parent became physically aggressive toward the child for unknown reasons. The parent kicked down the door and kicked the child in the ribs. It was unknown if the child sustained injuries. The parent was overwhelmed and frustrated with caring for the child.

Report Determination: Unfounded | **Date of Determination:** 08/20/2024

Basis for Determination:
The Investigation Conclusion Narrative reflected there was not a fair preponderance of evidence to substantiate the concerns. The parent set rules and consequences for the child.

OCFS Review Results:
The investigation was initiated timely, and the source was contacted. A CPS history check was documented. Home visits were made, and the family was interviewed. Collateral contacts were made. The Safety Assessments were completed with accuracy. The case record contained inaccurate information. The parent had multiple PIDS that were not merged, there was no citation issued as the same issue was cited in the fatality investigation.

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

CPS - Investigative History More Than Three Years Prior to the Fatality

11/01/17- 12/28/17 The parent was UnSub for IG and PD/AM regarding the SC.

08/30/18-10/29/18 The parent was Sub for IG of the SC. Other adults were UnSub for IG, LS and PD/AM of the SC.

12/13/18-02/04/19 The parent was UnSub for IG, XCP and L/B/W regarding the SC.

04/23/19-05/10/19 The parent was Sub for IG and LS regarding the SC.

11/23/20-12/30/20 The parent was UnSub for IF/C/S, IG and LS of the SC.

Known CPS History Outside of NYS

There is no known CPS history outside of New York.

Preventive Services History

A Services case was opened on 10/15/18 as the parent left the SC with inappropriate caregivers who were impaired by marijuana. The adults were unable to properly supervise the SC. There were concerns for the parent's mental health impacting her ability to care for the SC. The parent did not receive appropriate treatment, and the SC left the home unsupervised. On 04/23/19, the parent left the SC unsupervised and was arrested as a result. An Article 10 Neglect Petition was filed against the parent on behalf of the SC. The SC was initially placed in kinship Foster Care; however, was transferred to alternative placement on 05/07/19. There was a finding of Neglect on 02/24/20. The SC was returned to the parent under court-ordered supervision. The parent met the terms of supervision, and the case was closed on 04/27/21.

A Services case was opened on 12/13/24 as the parent requested to voluntarily place the SC into Foster Care. The parent was unable to control the SC's behaviors, including her aggression and truancy. The family was provided with case management services. The SC began residing with a friend and was transferred to another school. The parent believed the friend could provide the SC with more support and structure. The case was closed on 02/19/25 as the family was no longer accepting services.

Foster Care Placement History

On 04/23/19, on an emergency basis, the SC was removed from the parent as the parent moved 4 men into the home and allowed the adults to misuse marijuana in the SC's presence, and the SC was left unattended. The SC was placed with her godmother. The godmother was unable to care for her, and she was placed in a Foster Home on 05/07/19. An Article 10 Neglect Petition was filed against the parent on 04/24/19. Services provided to the family included mental health services and family support services. On 02/24/20, the SC was discharged from Foster Care with the terms of a 12-month Order of Supervision. The family met all requirements and reached identified goals. The case was closed on 04/27/21.

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