Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-25-061

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

Issue Date: Nov 17, 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: 5 month(s)
Jurisdiction: Queens
Gender: Male
Date of Death: 06/12/2025
Initial Date OCFS Notified: 06/12/2025

Presenting Information

The SCR report alleged that on 6/12/25, at an unknown time, the father found the subject child not breathing on the parents' bed. The father called 911 at 11:54 AM, and emergency medical services responded. Law enforcement and emergency medical services performed cardiopulmonary resuscitation on the subject child and transported him to the hospital. Hospital staff continued to perform cardiopulmonary resuscitation on the subject child; however, he was pronounced deceased at 12:24 PM. The SCR report alleged the subject child was an otherwise healthy child, and the father did not have an explanation for his death.

Executive Summary

This fatality report concerns the death of the 5-month-old male subject child who died on 6/12/25. The SCR report contained allegations of DOA/Fatality and Inadequate Guardianship against the mother and father. There was an open Family Assessment Response (FAR) case at the time of the subject child's death, with concerns regarding the condition of the home. At the time of his death, the subject child resided in the basement of a shared home with his mother, father, and 1-year-old surviving sibling. The maternal great-grandmother resided upstairs in the home, and an unrelated adult and her three children resided in another part of the basement. There may have been additional individuals residing and/or visiting the home at the time; however, it was unclear based on the record.

The Administration for Children's Services (ACS) completed casework and collateral contacts, and learned that on 6/12/25 around 8:00 AM, the father fed and burped the subject child and placed him in a baby lounger on his stomach inside of a crib. The father turned the subject child's face to the side and placed a blanket over him. The father then went to sleep in the full-sized bed with the sibling. Around 11:40 AM, the father awoke and observed the subject child unresponsive. The father called 911 and put the subject child on the floor to begin cardiopulmonary resuscitation until emergency medical services arrived. Emergency medical services continued life-saving measures and transported the subject child to the hospital, where he was later pronounced deceased.

An autopsy was performed; however, it had not been received by ACS at the time of their case closure. The Office of Children and Family Services received a copy of the autopsy at the time this report was written. The subject child's cause of death was listed as sudden unexplained infant death with intrinsic and extrinsic factors, and the manner was undetermined. The extrinsic factors were noted to be that the subject child was placed to sleep with his head turned in a baby lounger with a blanket and found with his face covered by the blanket. The intrinsic factors were that the child tested positive on a nasal swab for human metapneumovirus and human rhinovirus/enterovirus. The subject child was also noted in his neuropathology examination to have microscopic features of unknown significance. There were no noted injuries or trauma to the subject child. Law enforcement found no criminality related to the subject child's death, and no charges were filed.

Bereavement services were offered to the family, and a preventive services case was opened to continue assisting the family with services following the death of the subject child. The FAR case was closed upon receipt of the SCR report regarding the fatality. The safety assessments and risk assessment were completed inaccurately, documentation was fragmented, and the allegation of DOA/Fatality against the mother was inaccurately determined. All other allegations were appropriately substantiated, and the CPS case was indicated and closed on 8/8/25.

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:**
  - **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?** No

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:

While ACS appropriately indicated the CPS report, the allegation of DOA/Fatality was inaccurately substantiated against the mother, who was not home at the time of the subject child's death.

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:

Casework activity was not commensurate with case circumstances. The allegation of DOA/Fatality was inappropriately substantiated against the mother, the safety assessments were completed inaccurately, and the documentation was fragmented. There was contradictory information regarding the death of the subject child that was not fully explored or appropriately documented.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	The allegation of DOA/Fatality was inaccurately substantiated against the mother, who was not home at the time of the subject child's death. At the time of the fatal incident, the father fed the subject child and placed him on his stomach in a baby lounger. Before leaving for work, the mother last observed the subject child on his back in the crib. Additionally, a safe plan was created for the sibling regarding safe sleep and the condition of the home, and a neglect petition was considered; however, no allegations were ever added related to the sibling.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	ACS will refer to the CPS Program Manual when determining the appropriateness of allegations, and will consult with the New York City Regional Office if further guidance is needed.
Issue:	Adequacy of Documentation of Safety Assessments
Summary:	The 24-hour, 7-day, and 30-day safety assessments included safety factors related to the deceased child. Additionally, safe sleep was noted as a safety factor for the surviving sibling who turned 2 years old during the investigation and was over the age where safe sleep would pose an immediate or impending danger. However, ACS created a safety plan, and the safety decision was listed as a 3.
Legal Reference:	18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
Action:	The results of each safety assessment must be accurately documented in the case record to reflect case circumstances regarding safety.
Issue:	Case record contains information that is relevant, useful, factual and objective
Summary:	Documentation was fragmented and inconsistent. Case conferences included information not otherwise reflected in the progress notes, and therefore, pertinent information was missing from the case record. There were various accounts of the circumstances surrounding the subject child's death, including whether or not the sibling was sharing a crib with the subject child and found sitting on top of him. It was unclear from the case record if this was addressed directly with the parents, and what the outcome of that discussion was.
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.
Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	The Risk Assessment Profile reflected substance misuse for the mother that had a negative impact on the child(ren). While the mother admitted to marijuana use, the record did not support that this negatively affected 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 in the Risk Assessment Profile.
Issue:	Pre-Determination/Nature, Extent and Cause of Any Condition

Summary:	Circumstances surrounding the subject child's death and information provided to collateral sources regarding events related to the fatality were not fully explored with the mother and father.
Legal Reference:	18 NYCRR 432.2(b)(3)(iii)(c)
Action:	ACS will make an adequate assessment of the nature, extent, and cause of any condition which may constitute abuse or maltreatment, whether contained in the original SCR report or discovered during the open investigation.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/12/2025 **Time of Death:** 12:24 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: 11:54 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? No
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	24 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	22 Year(s)
Deceased Child's Household	Sibling	No Role	Female	1 Year(s)

LDSS Response

Upon receipt of the SCR report, ACS coordinated their investigation with law enforcement, notified the district attorney's office, completed a CPS history review, conducted a home visit, assessed the safety of the sibling and all other children in the home, and offered fatality-related services.

The mother and father were interviewed, and reported that the mother left for work around 7:45 AM. At that time, the mother observed the subject child asleep on his back in the crib, with blankets folded at the foot of his crib. The father reported that after the mother left for work, around 8:00 AM, he fed the subject child 7 ounces of formula and burped him for 20 minutes. Around 8:30 AM, the father placed the subject child on his stomach with his face turned to the side on a baby lounger located in the crib. The father then placed a blanket over the subject child. The father reported putting the sibling to sleep next to him in the full-sized bed and going to sleep himself. Around 9:00 AM, the father stated he woke up and observed the subject child asleep and breathing. Around 11:40 AM, the father awoke and observed the subject child unresponsive. The father stated that he knew immediately upon looking at the subject child that he was deceased. The father picked the subject child up, and he was limp. The father called 911, placed the subject child on the floor, and began cardiopulmonary resuscitation. Emergency medical services responded and continued life-saving measures. The subject child was transported to the hospital and pronounced deceased at 12:24 AM.

During the investigation, ACS was made aware of contradictions in the father's initial account of the circumstances surrounding the subject child's death. A collateral source reported to ACS that when asked about the death of the subject child, the father stated the sibling was also placed to sleep in the crib with the subject child and was found sitting on top of him. The record did not reflect that this was addressed with the father. Documentation stated that the mother and father both admitted that this had occurred; however, the record was fragmented, and it was unclear if this was in relation to the fatal incident or occurred on a separate occasion. In a separate discussion, the father reported he was doing "tummy time" with the subject child, in which he propped a tablet up for the subject child to watch cartoons. A family member also made a comment, "if only he was in his crib," to ACS, but the record did not reflect that this was addressed with the parents.

The mother and father both reported being aware of safe sleep guidelines prior to the subject's death, and were previously provided safe sleep provisions, including a portable crib and toddler bed for the sibling. The mother reported that the subject child usually slept in a lounger in the crib at night, but that the subject child and sibling would take naps together in the crib during the day.

The pediatrician confirmed the subject child was up to date with immunizations, and she had no prior concerns regarding the subject child or sibling and the care the parents provided. The pediatrician did note that the subject child had an abnormal thyroid reading, but that the mother had not followed up for further testing. The sibling was seen medically after the subject child's death, and there were no concerns for her.

A preventive services case was opened due to concerns regarding the condition of the home, and it remained open at the time the CPS case closed to continue assisting the family with services. The sibling was deemed safe with the parents.

Official Manner and Cause of Death

Official Manner: Undetermined

Primary Cause of Death: From a 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: While NYC has an OCFS-approved Child Fatality Review Team, it is unknown whether this case has been referred.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
072772 - Deceased Child, Male, 5 Month(s)	072773 - Mother, Female, 22 Year(s)	Inadequate Guardianship	Substantiated
072772 - Deceased Child, Male, 5 Month(s)	072774 - Father, Male, 24 Year(s)	DOA / Fatality	Substantiated
072772 - Deceased Child, Male, 5 Month(s)	072773 - Mother, Female, 22 Year(s)	DOA / Fatality	Substantiated
072772 - Deceased Child, Male, 5 Month(s)	072774 - Father, Male, 24 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?	☐	☒	☐	☐

Explain as necessary:
No children needed to be removed.

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? Yes
Explain:

The family was engaged in preventive services at the close of the CPS investigation to address ongoing concerns regarding the SS and the condition of the home.

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, and accepted by, the family. A preventive services case was opened, and referrals to services, including parenting, mental health, and bereavement, were made.

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? Yes

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
05/14/2025	Deceased Child, Male, 4 Months	Mother, Female, 22 Years	Inadequate Food / Clothing / Shelter	Far-Closed	Yes
	Sibling, Female, 1 Years	Mother, Female, 22 Years	Inadequate Food / Clothing / Shelter	Far-Closed	
	Deceased Child, Male, 4 Months	Father, Male, 24 Years	Inadequate Food / Clothing / Shelter	Far-Closed	
	Sibling, Female, 1 Years	Father, Male, 24 Years	Inadequate Food / Clothing / Shelter	Far-Closed	

Report Summary:
The SCR report alleged that the SM, SF, and three unknown home members did not address the unsanitary conditions in the home where the SS and SC resided. The floors were cluttered with dirty clothing, garbage, and old food. The floors were cluttered to the point that they were not walkable.

OCFS Review Results:
ACS initiated their investigation timely, and completed documentation accurately. Safe sleep was not reviewed with the caregiver of two unrelated infants residing in the shared home.

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

Issue:

Failure to provide safe sleep education/information

Summary:

During the course of the investigation, it was discovered that two other infants under the age of one were residing in the same shared residence as the mother and father. The record did not reflect that safe sleep guidelines were discussed with the caregivers of those infants. Safe sleep provisions were not observed for those children.

Legal Reference:

13-OCFS-ADM-02 & CPS Program Manual, Chapter 6, J-1

Action:

ACS will provide information on sleep safety to the parents and caretakers of infants and parents-to-be whom they encounter and see that parents and caretakers take the steps necessary to provide safe sleeping conditions for the children in their care.

[redacted]

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 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