Child Fatality Report

Report Identification Number: NY-25-064

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

Issue Date: Oct 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		

Case Information

Report Type: Child Deceased
Age: 3 month(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 06/30/2025
Initial Date OCFS Notified: 06/30/2025

Presenting Information

An SCR report was received on 6/30/25, that alleged on the same date, at an unknown time, the maternal grandmother, 16-year-old maternal aunt, and the subject child were all sharing a bed in the home. At approximately 12:07PM, the subject child was found unresponsive and not breathing. The family contacted 911. EMS arrived at the home at an unknown time and attempted CPR on the subject child. EMS transported the subject child to the hospital where she was pronounced deceased at 1:53PM. The subject child passed away as a result of the unsafe sleeping arrangement.

Executive Summary

The New York City Administration for Children's Services (ACS) received an SCR report on 6/30/25, concerning the death of the 3-month-old female subject child. At the time of her death, the subject child resided with her mother, a roommate, and the roommate's child. There was a 4-year-old surviving sibling who resided out of the country with her paternal grandmother. The surviving sibling's and the subject child's fathers resided out of the country.

The subject child was home with the 16-year-old maternal aunt when she was found unresponsive. The 16-year-old maternal aunt resided in the apartment upstairs with the maternal grandmother, three other adults, and seven other children. ACS visited the home and saw all but one of the children. ACS determined the children were safe in the home with the maternal grandmother and three other adults.

ACS learned that the subject mother was at work while the 16-year-old maternal aunt cared for the subject child at the subject child's home. After feeding the subject child a bottle of formula, the aunt laid the sleeping child on the bed next to her and went to sleep. When the aunt woke, she found the subject child unresponsive and called for the maternal grandmother. They contacted the subject mother and 911. The subject child was transported to the hospital where he was pronounced deceased.

ACS spoke with the medical examiner and law enforcement. An autopsy was completed. At the time of this writing, the final autopsy results were pending, and law enforcement was waiting for the toxicology results to determine their investigation. Law enforcement spoke with the medical examiner, who indicated there were no signs of trauma on the child.

There was a fair preponderance of evidence to support the allegations of Inadequate Guardianship and DOA/Fatality against the subject mother. The Investigation Determination Narrative explained the subject mother had been utilizing a bassinet for storage instead of using it as a safe sleep space for the subject child, she had not been practicing safe sleep recommendations and did not provide a safe sleep space for the subject child while she was in the care of the 16-year-old maternal aunt. The allegations of Inadequate Guardianship and DOA/Fatality were appropriately unsubstantiated against the maternal grandmother.

ACS completed mental health referrals for the subject mother, maternal grandmother and the 16-year-old maternal aunt. There was no documentation of ACS providing bereavement resources for the other family members. ACS began the process of coordinating funeral assistance for the family; however, the family completed the process without ACS' assistance.

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:
The allegations were appropriately substantiated against the subject mother.

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes

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

Explain:
Casework was commensurate with case circumstances.

Required Actions Related to the Fatality

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

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/30/2025 **Time of Death:** 01:53 PM

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: 12:08 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? Unknown
Child's activity at time of incident:

- ☒ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☐ Unknown
- ☐ Other

Total number of deaths at incident event:
Children ages 0-18: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	3 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	24 Year(s)
Other Household 1	Aunt/Uncle	No Role	Female	16 Year(s)
Other Household 1	Grandparent	Alleged Perpetrator	Female	44 Year(s)
Other Household 2	Father	No Role	Male	24 Year(s)

LDSS Response

ACS began their investigation within 24 hours, contacted the source, and competed a CPS history review. ACS coordinated with law enforcement, attempted to communicate with the medical examiner, and notified the district attorney and the CAC.

ACS spoke with the subject mother, maternal grandmother and 16yo maternal aunt, who provided the same account of events. Before work, the subject mother went upstairs and asked the aunt to watch the SC. The subject mother left for work at 8:45AM, while the aunt stayed with the SC in the SC's home. At 9:45AM, the aunt fed the SC a bottle of formula. During the feeding, the SC fell asleep. The aunt placed the SC on her stomach, on the bed, with her head to the side. The SC was placed closest to the wall while the aunt laid on the other side of her. The aunt placed pillows around the SC to prevent her from rolling off the bed. The aunt fell asleep and woke around 12:05PM, and saw the SC was between the bed and the wall with her legs pointed in the air. The aunt observed the SC to not be breathing, with blood coming out of her nose. The aunt yelled for the grandmother, who ran downstairs and observed the SC unresponsive. They called the subject mother and 911, and performed CPR. EMS arrived and continued CPR on the SC. The subject mother arrived and

accompanied the SC to the hospital in an ambulance. The SC was pronounced deceased at 1:53PM.

ACS observed the home. There was a bassinet in the subject mother's room, between the bed and wall. The bassinet appeared to be used for storage and had multiple baby items in it. The subject mother and aunt confirmed the bassinet was in the same state during the fatal incident. The 16yo aunt reported that she did not place the SC in the bassinet because the SC did not like to be in there. She did not lay the SC on her back because it would have woken the SC up. The aunt used a doll to show ACS where she placed the SC on the bed. The aunt reported that the SC was able to roll.

ACS spoke with law enforcement, and it was determined the family provided the same information to them as they provided to ACS. Law enforcement reported an additional detail, that the aunt placed a blanket over herself and the SC before going to sleep. ACS spoke with hospital staff. The SC arrived at the hospital in cardiac arrest at 12:42PM. They performed life-saving measures for about an hour. There were no concerns that the SC had physical trauma. ACS attempted to contact EMS.

ACS spoke with another maternal aunt. She reported she was in her room at 12:06PM, when she heard the 16yo maternal aunt screaming for the grandmother because the SC was unresponsive. ACS spoke with the subject mother's roommate who reported she was not at home at the time of the incident and had no concerns for the care of the SC. ACS spoke with both biological fathers who resided out of the country. They did not have any additional information pertaining to the fatal incident. ACS observed the 4yo SS over a video chat to determine she was safe in the care of her paternal grandmother.

ACS completed the Safety and Risk Assessment's timely. ACS entered progress notes and completed their investigation timely. Appropriate collaterals were contacted and spoke with out of country relatives.

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: The New York City region does not have an OCFS-approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
072259 - Deceased Child, Male, 3 Month(s)	072260 - Mother, Female, 24 Year(s)	DOA / Fatality	Substantiated
072259 - Deceased Child, Male, 3 Month(s)	072260 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Substantiated
072259 - Deceased Child, Male, 3 Month(s)	072261 - Grandparent, Female, 44 Year(s)	DOA / Fatality	Unsubstantiated

072259 - Deceased Child, Male, 3 Month(s)	072261 - Grandparent, Female, 44 Year(s)	Inadequate Guardianship	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐
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?	☒	☐	☐	☐
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:
Therapy referrals were completed for the mother, maternal grandmother and maternal aunt. Funeral assistance was offered. Bereavement services were not offered to all the surviving children.

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 16yo maternal aunt was provided with a referral for trauma therapy.

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:
Referrals were completed for the mother and maternal grandmother for trauma therapy and funeral assistance was offered.

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.

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