Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-25-069

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

Issue Date: Oct 14, 2025 **(Report was reissued on: 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: 4 year(s)
Jurisdiction: Kings
Gender: Male
Date of Death: 07/07/2025
Initial Date OCFS Notified: 07/07/2025

Presenting Information

The mother, father, and subject child were swimming in a pond. The subject child exited the water and was not properly supervised while the parents stayed in the pond. After 30 minutes, the parents did not know where the subject child was and had last seen him alive at 12:40PM. At an unknown time, the subject child was found at the bottom of the pond and had drowned. The subject child was subsequently transported to the hospital. He was pronounced deceased on 7/7/25 at 4:01AM.

Executive Summary

The New York City Administration for Children's Services (ACS) received an SCR report concerning the death of the 4-year-old male subject child. At the time of his death, the subject child resided with his mother, father and 6-year-old surviving sibling in the New York City region; however, they were on vacation in Delaware County when the subject child drowned. ACS assessed the surviving sibling to be safe in the care of his parents.

ACS learned that on 7/4/25, the family had been on vacation with seven other families. Everyone was at the pond; swimming, playing and socializing, when the subject mother noticed the subject child was missing. Everyone stopped what they were doing and began searching for the subject child. A family friend eventually found the subject child submerged in the pond. The subject child was taken out of the pond and life-saving measures were performed. While 911 was contacted, it took EMS almost an hour to arrive. The subject child was transported to the closest hospital and then transported to a more equipped hospital. The subject child was on life support until 7/7/25, when he was pronounced deceased at 4:01AM.

An autopsy was performed by the medical examiner. It was determined that the subject child died because of an accidental drowning. No foul play was suspected. The final autopsy report was pending. Law enforcement was on scene and spoke with approximately 22-23 people that were present at the time of the incident and were able to determine that there was no criminal negligence by the parents.

ACS appropriately substantiated the allegations of Lack of Supervision and DOA/Fatality against both parents.

ACS provided the family with bereavement resources, prior to case closure the family engaged in therapy. There was no documentation of ACS offering the family funeral 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 of Lack of Supervision and DOA/Fatality were appropriately substantiated against the parents

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.

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: 07/07/2025 **Time of Death:** 04:01 AM

Date of fatal incident, if different than date of death: 07/03/2025
Time of fatal incident, if different than time of death: 12:50 PM

County where fatality incident occurred: Delaware
Was 911 or local emergency number called? Yes
Time of Call: 01:02 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	4 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	46 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	44 Year(s)
Deceased Child's Household	Sibling	No Role	Male	6 Year(s)

LDSS Response

ACS began their investigation immediately, contacted the source and completed a CPS history review. ACS coordinated with law enforcement, notified the district attorney, and spoke with the medical examiner, hospital staff and family collaterals. ACS did not attempt to speak with EMS.

The parents provided the same account of events to ACS and law enforcement. The family was at a campsite with seven other families. The morning of the fatal incident, they woke and had breakfast before meeting the other families at the pond. They arrived at the beach at 12:10PM and laid a mat down and set up an area. The 6yo SS and subject father went into the water immediately. About 10 minutes later, the subject mother and SC went in the water. The mother put a floatation device on the SC prior to entering the pond. The parents reported that the SC swam back and forth between them; however, they were in the shallow end, and the SC was able to stand up. Shortly after entering the pond, the children were ready to get out. The mother followed them out of the water, took off the SC's floatation device and dried him, and then left the children to play in the sand while she went back into the water. The parents reported that while they were in the water they were looking at the children often. The father explained they would give a "thumbs up" signal to the children and yell out to the children, and the children would give the signal back. The father explained the mat was approximately 10-15ft from the water and the parents were approximately 25-30ft from the mat.

Another adult approached the mother and started a conversation. After a minute or two, the mother realized she could not see the SC. The mother got out of the water and began searching, everyone stopped what they were doing to help. The father walked back to the campsite in case the SC went back there. On the way, the father told a park ranger the situation and staff locked the gate to the park. A family friend got on a paddle board and began searching the water, where he found the SC submerged. He carried the SC out of the water and began performing CPR. The mother observed the SC's tongue to be blue. EMS arrived and took over life-saving measures and transported the SC to the hospital.

The 6yo SS told ACS that he and his family were camping when his brother sank in the water. He explained he and his family were in the water, and he and the SC got out of the water. He stated the SC was playing with sand toys. The 6yo SS got up and went to put his feet in the water. He stated when he looked back the SC was gone. He reported he did not see the SC enter the water. He confirmed that the SC had a floatation device on when he had been in the water. The SS reported that his parents were in the water while him and the SC were on land. ACS asked the SS if his parents were checking on him and the SC while they were on land, and the SS said no, the parents did not call out to them and were having fun with other parents.

ACS spoke with two adults that were present on vacation. One adult watched the SS for a few hours while the parents were at the hospital and stated he would still trust the parents to watch his child. The other adult was the friend that found the SC. He reported finding the SC 10-15ft from the beach and about 7-10ft deep and explained he had known the SC's mother to be very attentive. ACS also spoke with another family friend and a cousin. None of the adults had any concerns for the parents' care of the children.

ACS completed the investigation, fatality reports and the safety and risk assessments timely and accurately. Progress notes were entered contemporaneously, and appropriate notifications were provided to the family.

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
072269 - Deceased Child, Male, 4 Year(s)	072270 - Mother, Female, 44 Year(s)	DOA / Fatality	Substantiated
072269 - Deceased Child, Male, 4 Year(s)	072271 - Father, Male, 46 Year(s)	DOA / Fatality	Substantiated
072269 - Deceased Child, Male, 4 Year(s)	072270 - Mother, Female, 44 Year(s)	Lack of Supervision	Substantiated
072269 - Deceased Child, Male, 4 Year(s)	072271 - Father, Male, 46 Year(s)	Lack of Supervision	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	☐	☒	☐	☐
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	☒	☐	☐	☐

Explain:
The Risk Assessment Profile was completed accurately.

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	☐	☐	☐	☐	☐	☒

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 provided with bereavement resources.

Were services offered to and/or received by parent(s) and other care givers at the time of and/or in response to the fatality? Yes
Explain:
The family was provided with bereavement resources. There was no documentation that the family was provided with funeral assistance.

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

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