Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-25-078

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

Issue Date: Nov 14, 2025 **(Report was reissued on: 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

Jurisdiction: Office Of Special Investigations

Date of Death: 08/01/2025

Age: 1 year(s)

Gender: Female

Initial Date OCFS Notified: 08/01/2025

Presenting Information

An SCR report was received on 8/1/25, which stated the daycare provider failed to provide adequate supervision of the 1-year-old subject child. As a result, the child opened the door, exited the home, climbed the stairs and fell into the pool. The child drowned in the pool and was unable to be resuscitated. The child was pronounced deceased at 1:38pm. It was unknown how long it took the daycare provider to notice the child absent from the home. The mother and the father were not present and had no roles.

Executive Summary

This report concerns the death of a 1-year-old female child. On 8/1/25, Administration for Children's Services (ACS) received an SCR report regarding the subject child's death. At the time of the child's death, she resided with her mother and father. There were no surviving siblings. The daycare provider had an 11-year-old child who was assessed to be safe in her care.

ACS completed casework and collateral contacts, and learned that on 8/1/25, the mother dropped the subject child off at the daycare provider's in-home, licensed daycare around 11:40am. The daycare provider then went into the kitchen to cook lunch while the child played in the living room. At approximately 12:30pm, the daycare provider realized the child was no longer in the living room and informed her adult daughter, who was also in the home. They began looking for the child and eventually located her in the backyard, submerged in the swimming pool. The daycare provider removed her from the water, called 911, began cardiopulmonary resuscitation, and called the child's mother. Emergency medical services responded to the home and continued life-saving measures. The subject child was transported to the hospital where she was pronounced deceased at 1:38pm.

An autopsy was completed, and the final cause and manner of death were pending at the time of this report. However, the medical examiner stated her unofficial cause of death was accidental drowning. Law enforcement investigated the fatal incident, and the investigation remained open pending the final autopsy results.

The allegations of DOA/Fatality, lack of supervision and inadequate guardianship against the daycare provider, were substantiated due to the preponderance of the evidence. The daycare provider admitted that she lost sight of the child while she was cooking in the next room. She further stated that once she realized the child was missing, she spent approximately twenty minutes looking around the daycare for her before finding her submerged in the swimming pool. According to the NYS Department of Health, the daycare provider was not licensed to have any daycare children in the backyard of her home, because the pool area was not approved as part of the daycare. As a result of the fatal incident, the daycare provider's daycare license was revoked.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** N/A

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
The investigation was appropriately determined.

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:
Safety and Risk Assessments are not required in daycare cases. ACS assessed the daycare provider's child within 24 hours and he was assessed safe. There were no additional service needs identified throughout the investigation and the case was closed.

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: 08/01/2025 **Time of Death:** 01:38 PM

Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? Yes
Time of Call: 12:51 PM
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	Female	1 Year(s)
Deceased Child's Household	Father	No Role	Male	39 Year(s)
Deceased Child's Household	Mother	No Role	Female	34 Year(s)
Other Household 1	Day Care Provider	Alleged Perpetrator	Female	47 Year(s)

LDSS Response

On 8/1/25, an SCR report was received regarding the death of a 1-year-old female subject child. ACS initiated their investigation immediately, spoke with the source of the report, coordinated with law enforcement, completed a CPS history review and conducted interviews.

ACS interviewed the daycare provider and the biological mother, and learned that on 8/1/25, the mother dropped the subject child off at the daycare provider's in-home, licensed daycare around 11:40am. The daycare provider then went into the kitchen to cook lunch while the child played toys in the living room. At approximately 12:30pm, the daycare provider realized the child was no longer in the living room and informed her daughter, who was also in the home. They began looking for the child and eventually located her in the backyard, submerged in the swimming pool. The daycare provider removed the child from the water, called 911, began cardiopulmonary resuscitation, and called the child's mother. Emergency medical services responded to the home and continued life-saving measures. The subject child was transported to the hospital where she was pronounced deceased at 1:38pm.

The biological father was at home at the time of the fatal incident. He stated a neighbor informed him what had happened, and he ran to the daycare. When he arrived, he witnessed EMS attempting to resuscitate the subject child. He then accompanied her to the hospital.

The daycare provider's family members were also interviewed. The daycare provider's husband and 11-year-old son were not home at the time of the fatal incident. The daycare providers adult son was sleeping at the time and her adult daughter refused to speak with ACS without her attorney present.

ACS also interviewed neighbors who stated they heard the daycare provider screaming for help, so they ran over to assist with CPR until EMS arrived. They stated the day care provider was distraught during the fatal incident.

Bereavement services were offered to the parents but were declined. Grief counseling services were not offered however, the daycare provider and the subject child's family, refused any further contact with ACS without their attorney's present.

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: While NYC has an 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
072420 - Deceased Child, Female, 1 Year(s)	072423 - Day Care Provider, Female, 47 Year(s)	DOA / Fatality	Substantiated
072420 - Deceased Child, Female, 1 Year(s)	072423 - Day Care Provider, Female, 47 Year(s)	Inadequate Guardianship	Substantiated
072420 - Deceased Child, Female, 1 Year(s)	072423 - Day Care Provider, Female, 47 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?	☒	☐	☐	☐
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?	☐	☐	☒	☐

Explain:
The tools for safety assessments and the Risk Assessment Profile (RAP) are not available for daycare cases. Although safety assessments in these instances are not required, ACS did assess and document the safety of the daycare providers child.

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	☐	☐	☐	☐	☐	☒

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:
Bereavement services were offered to the parents but were declined. Grief counseling services were not offered however, the daycare provider and the subject child's family, refused any further contact with ACS without their attorney's present.

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

Allegations from the SCR report dated 12/24/19 of inadequate guardianship and lack of supervision were substantiated against the daycare provider, while she was in the role of foster parent. The daycare provider/foster parent failed to provide appropriate supervision of the foster child while she was in the bathroom, resulting in the foster child burning himself with a microwave food item.

Allegation from the SCR report dated 11/01/19 of inadequate guardianship, was unsubstantiated against the daycare provider, while she was in the role of foster parent.

Allegation from the SCR report dated 02/01/16 of inadequate guardianship, was unsubstantiated against the daycare provider, while she was in the role of foster parent.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity.

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? ☐Yes ☒No

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No