Child Fatality Report

Report Identification Number: NY-25-091

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

Issue Date: Dec 30, 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: 1 year(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 09/15/2025
Initial Date OCFS Notified: 09/15/2025

Presenting Information

An SCR report was received that alleged that on the night of 9/14/25 around 7:30PM, the subject mother and the subject father put the 1-year-old subject child in the crib to sleep. On the morning of 9/15/25 around 8:50AM, the subject father checked on the subject child and found her face down in the crib with vomit around her. The subject father immediately called for emergency medical services (EMS) and performed cardiopulmonary resuscitation (CPR) on the subject child. EMS arrived at the home within a minute of being called and pronounced the subject child deceased on scene at 9:04AM. The subject mother and subject father could not provide an explanation for subject child's death.

Executive Summary

This report concerns the death of the 1-year-old female subject child that occurred on 9/15/25. On the same date, the New York City Administration for Children's Services (ACS) received an SCR report with allegations of Inadequate Guardianship and DOA/Fatality against the subject father and subject mother regarding the subject child. At the time of the child's death, she resided with her father, mother, nanny, and five surviving siblings aged 10, 9, 7, 5, and 1-month-old. The surviving siblings were deemed safe in the care of their parents.

Through a joint investigation with law enforcement, it was learned on 9/15/25, the subject child was found in her crib unresponsive with vomit around her. Emergency medical services (EMS)were called. The subject father performed cardiopulmonary resuscitation to no avail. EMS arrived at the home within minutes of being called and pronounced the child deceased at 9:04AM.

ACS spoke with the medical examiner who reported that there was no autopsy performed on the subject child due to religious beliefs; however, there was an external examination completed. There were no obvious injuries or trauma observed on the child's body. The cause of death was listed as undetermined, and the manner of death was of natural causes. The body was released to the family on 09/15/25.

ACS communicated with law enforcement who advised their case was closed as the death was classified as DOA non-criminal and they do not investigate DOA's.

ACS was justified in substantiating the allegation of Inadequate Guardianship against the parents regarding the subject child as they failed to seek medical attention when the child was ill. Additionally, the parents administered a medication to the subject child to treat her illness that was prescribed for one of the surviving siblings. ACS substantiated the allegation of DOA/Fatality against both parents regarding the subject child despite a lack of a fair preponderance of evidence.

The record reflected that ACS worked with the family to ensure that there were adequate supports and resources offered. The family was offered bereavement services which were declined. The family advised that they were relying on family and their religious community as support systems during their time of grief.

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?** 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?** No

Explain:
ACS made an appropriate determination regarding the allegation of IG; however, there was not a fair preponderance of evidence to substantiate the allegation of DOA/Fatality against the parents.

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:
The level of casework activity was not commensurate with the case circumstances.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	ACS substantiated the allegation of DOA/Fatality against both parents regarding the subject child despite a lack of a fair preponderance of evidence.

Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	ACS will refer to the CPS Program Manuel when determining the appropriateness of allegations and will consult with the NYC Regional Office if further guidance is needed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 09/15/2025 **Time of Death:** 09:04 AM

Time of fatal incident, if different than time of death: 08:50 AM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 09:01 AM
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	Female	1 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	35 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	30 Year(s)
Deceased Child's Household	Sibling	No Role	Male	10 Year(s)
Deceased Child's Household	Sibling	No Role	Female	9 Year(s)
Deceased Child's Household	Sibling	No Role	Female	7 Year(s)
Deceased Child's Household	Sibling	No Role	Female	5 Year(s)
Deceased Child's Household	Sibling	No Role	Female	1 Month(s)

Deceased Child's Household	Unrelated Home Member	No Role	Female	40 Year(s)

LDSS Response

On 9/15/25, ACS received an SCR report regarding the death of the 1-year-old SC which occurred on the same date. ACS initiated their investigation within 24 hours and notified the district attorney, communicated with the medical examiner's office, and coordinated their efforts with law enforcement. ACS contacted the source of the report, completed a CPS history check, and learned there were five surviving siblings aged 10, 9, 7, 5 and 3-weeks-old.

ACS completed an interview with the subject parents who were able to provide a timeline of events leading up to the SC's death. Both reported that on 9/12/25, the SC developed a barking cough. The parents did not seek medical attention and decided to treat the cough by giving the SC a dose of medication that had been previously prescribed to one of the surviving siblings. On Sunday, 9/14/25, the SC threw up. The SC was cleaned up and the subject mother put the SC to sleep around 8:00PM. The subject father reported that on 9/15/25, he was making breakfast for the family and around 8:40AM he went and checked on the SC. Upon entering the SC's bedroom, he found her unresponsive. The SF refused to answer what state the SC was in when he found her. The subject father called EMS and performed CPR to no avail. When EMS arrived at the home, they pronounced the SC deceased.

ACS interviewed the nanny who reported her sole responsibility in the home was to care for the newborn child. She was able to corroborate the parents account of events leading up to the SC's death. She reported no additional concerns.

ACS interviewed the SSs, none of whom had any additional information to add regarding the incident. None of the SSs reported anything concerning to ACS and all appeared to be free from visible marks or bruises.

ACS contacted numerous collateral resources, which included friends and family, who reported no concerns. The SSs were deemed safe in the care of the parents. The parents refused to sign HIPPA releases, and no autopsy was performed due to the family's religious beliefs.

Official Manner and Cause of Death

Official Manner: Undetermined

Primary Cause of Death: Unknown

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 New York City has an OCFS approved CFRT, it was unknown if this case had been referred.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome

072408 - Deceased Child, Female, 1 Year(s)	072410 - Father, Male, 35 Year(s)	DOA / Fatality	Substantiated
072408 - Deceased Child, Female, 1 Year(s)	072410 - Father, Male, 35 Year(s)	Inadequate Guardianship	Substantiated
072408 - Deceased Child, Female, 1 Year(s)	072409 - Mother, Female, 30 Year(s)	DOA / Fatality	Substantiated
072408 - Deceased Child, Female, 1 Year(s)	072409 - Mother, Female, 30 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?	☐	☒	☐	☐

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:
Bereavement services were offered to the family. Services were declined and the family was relying on family and their religious community for support.

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 family. Services were declined and the family was relying on family and their religious community for support.

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? Yes

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.

Known CPS History Outside of NYS

There is 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