Child Fatality Report

Report Identification Number: SV-25-013

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

Issue Date: Jul 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 Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	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-Case Worker	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: Nassau
Gender: Female
Date of Death: 03/18/2025
Initial Date OCFS Notified: 03/18/2025

Presenting Information

An SCR report was received on 3/18/25, which alleged that around 3:00AM, the mother fed the child and put her in bed to sleep. The mother and unknown children all slept in the same king-sized bed. There were blankets and pillows around the child. The mother woke up at 7:00AM and realized the child was not breathing. The mother did not perform any life-saving measures and called 911. Police and emergency medical services (EMS) arrived on the scene at 7:12AM. The police and EMS performed cardiopulmonary resuscitation (CPR). The child was transported to the hospital and pronounced deceased. It was alleged that the unsafe sleep situation contributed to the child's death. The condition of the home was a fire safety hazard for the children. The home was small and crowded with items such as boxes, furniture, and other household items. The items blocked the exits creating a fire hazard.

Executive Summary

This report concerns the death of a 3-month-old female child that occurred on 3/18/25. A report was made to the SCR on the same day, alleging that the mother was bedsharing with the 3-month-old child and later woke to find the child not breathing and unresponsive. She contacted the subject father who then contacted 911. Emergency medical services arrived at the home and transported the subject child to the hospital where she was pronounced deceased. At the time of the child's death, she resided at home with her mother and two surviving siblings, ages 3- and 7-years-old. Additional concerns regarding the unsafe condition of the home were also alleged.

Nassau County Department of Social Services (NCDSS) coordinated their investigative efforts with law enforcement upon receipt of the SCR report. The criminal case was closed without any criminality being found. They did not find any injuries to the child, nor evidence of abuse or neglect by either parent. Law enforcement had not made any arrests, and their investigation remained open, pending the autopsy report.

The medical examiner was notified and performed an autopsy of the child. The cause and manner of death were pending at the time this report was written.

NCDSS made collateral contact with the pediatrician. There were no documented concerns about the care that the mother provided to the children. The father did not reside in the home and had no concerns about the mother's care of the subject child or surviving siblings. The surviving siblings were assessed to be safe in the care of the mother.

Safety Assessments and required reports were completed timely and accurately. Notices of Indication were not provided to the adults.

NCDSS substantiated the allegations of Inadequate Guardianship and DOA/Fatality against the mother and Inadequate Guardianship against the father regarding the death of the child. The Investigative Conclusion Narrative states that when the mother moved, she did not take the subject child's crib and was not practicing safe sleep. In addition, the father was aware that the mother was not practicing safe sleep.

PIP Requirement

NCDSS will submit a PIP to the Westchester Regional Office within 30 days of receipt of this report. The PIP will identify action(s) the NCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, NCDSS 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?** Yes

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:
There was detailed documentation of supervisory consult.

Required Actions Related to the Fatality

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

Issue:	Contact/Information From Reporting/Collateral Source
Summary:	There were missed opportunities to gather collateral information from the household members who were present on the day of the fatality and were added to the case composition. In addition, there were no documented attempts to speak to hospital staff
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(b)
Action:	NCDSS will make diligent efforts to contact collaterals to attempt to gather relevant information as it pertains to safety, risk, and a determination of the allegations.

Issue:	Failure to Provide Notice of Indication
Summary:	NCDSS did not provide notification letters to the BM and BF.
Legal Reference:	18 NYCRR 432.2(f)(3)(xi)
Action:	NCDSS will mail or deliver notification letters to subject(s), parent(s), and any other adult(s) named in the report within the first seven days following the receipt of the report. When other persons are identified as residing in the household and added to the case, they will be notified in writing as well.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 03/18/2025 **Time of Death:** 07:36 AM

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

County where fatality incident occurred: Nassau
Was 911 or local emergency number called? Yes
Time of Call: 07:00 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	3 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	30 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	27 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	3 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	7 Year(s)

LDSS Response

On 3/18/25, NCDSS received a report regarding the death of the SC. NCDSS initiated their investigation within 24 hours and coordinated their efforts with law enforcement. NCDSS contacted the source of the report, completed a CPS history check regarding the family, and informed the DA of the fatality.

NCDSS made a home visit on 3/18/25 and interviewed the subject mother regarding the events leading up to SC's death. A timeline of the incident was provided. The mother reported that she fed the subject child at approximately 3:00AM and then placed her to sleep on the adult bed between herself and the surviving siblings around 3:30AM. The mother woke at 7:00AM and found the child unresponsive and not breathing. She immediately called the father, who she believed contacted 911 while she ran to get assistance from family members.

The subject father was interviewed by Suffolk County Department of Social Services (SCDSS) and reported that he had never lived with the mother, SC, or SSs due to his prior criminal conviction and arrest; however, he was aware that the mother had recently moved into a new residence. According to the father, the new residence was not big enough to hold the subject child's crib, so the family was bedsharing. The morning of 3/18/25, he received a frantic phone call from the mother, who stated that the subject child wasn't breathing. He told the mother to try to calm down and get help from family members while he called 911.

NCDSS interviewed the 7-year-old SS. He reported that his baby sister died, and now she was in heaven. He had no other information to add. Both SSs appeared free from visible marks and bruises and were assessed to be safe in the care of the mother. On 3/19/25, the mother and surviving siblings moved into the adjoining house to be with relatives after the fatality. The additional adult household members and the child were added to CONNECTIONS. The additional child was interviewed and did not have any concerns for the mother or SSs. There were no documented attempts to interview the household members who were added to the case composition.

NCDSS reached out to the medical examiner's office, which conducted the autopsy. At the close of the CPS investigation, the medical examiner reported that the cause and manner of death were still pending.

Pediatrician records showed that the infant was healthy, and she was up to date with immunizations and well visits.

NCDSS appropriately determined the allegations against the mother and father and closed the investigation on time.

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? Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
070592 - Deceased Child, Female, 3 Month(s)	070594 - Father, Male, 30 Year(s)	Inadequate Guardianship	Substantiated
070592 - Deceased Child, Female, 3 Month(s)	070593 - Mother, Female, 27 Year(s)	DOA / Fatality	Substantiated
070592 - Deceased Child, Female, 3 Month(s)	070593 - Mother, Female, 27 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
070592 - Deceased Child, Female, 3 Month(s)	070593 - Mother, Female, 27 Year(s)	Inadequate Guardianship	Substantiated
070592 - Deceased Child, Female, 3 Month(s)	070594 - Father, Male, 30 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
070595 - Sibling, Female, 3 Year(s)	070593 - Mother, Female, 27 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
070595 - Sibling, Female, 3 Year(s)	070594 - Father, Male, 30 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
070596 - Sibling, Male, 7 Year(s)	070593 - Mother, Female, 27 Year(s)	Inadequate Food / Clothing / Shelter	Unsubstantiated
070596 - Sibling, Male, 7 Year(s)	070594 - Father, Male, 30 Year(s)	Inadequate Food / Clothing / Shelter	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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
Family Members	☐	☒	☐	☐
Emergency Room Personnel	☐	☒	☐	☐
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?	☒	☐	☐	☐

Additional information:

There was no documentation that Nassau County reached out to first responders, hospital staff or other household members that were added to the investigation.

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:
Risk was assessed throughout the investigation and appropriate services in relation to the death of the SC were offered to the family.

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:
In response to the fatality, the family was provided with grief resources; however, it is unknown if the resources were utilized.

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.

Known CPS History Outside of NYS

There is no known CPS history outside of NY 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