Child Fatality Report

Report Identification Number: SV-25-024

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

Issue Date: Sep 23, 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: 27 day(s)
Jurisdiction: Suffolk
Gender: Male
Date of Death: 05/18/2025
Initial Date OCFS Notified: 05/18/2025

Presenting Information

An SCR report was received on 05/18/2025, alleging that at approximately 2:00am on the same day, the mother and father woke and fed the 3-week-old subject child. After the feeding, the mother and the father placed the child in the middle of the bed, and the parents slept on either side of him. At approximately 6:00am, the parents woke and found the child unresponsive, and blueish in color. The parents took the child out of the bed and placed him onto the floor. At approximately 6:08am, the mother called 911 and performed cardiopulmonary resuscitation (CPR). Emergency medical services (EMS) transported the child to the hospital where life-saving measures were continued; however, were unsuccessful. At 6:59am, the child was pronounced deceased. It was alleged that the unsafe sleeping arrangement contributed to the child's death.

Executive Summary

On 05/18/2025, Suffolk County Department of Social Services (SCDSS) received an SCR report regarding the death of the 3-week-old male subject child. The report contained allegations of DOA/ Fatality and Inadequate Guardianship against the subject mother and the subject father regarding the subject child. At the time of the subject child's death, he resided with his mother, father, 8-year-old male surviving half-sibling (SS1) and 8-year-old female surviving half-sibling (SS2). There were eight extended family members residing on different floors of the home as well. The surviving siblings were assessed to be safe in the care of their parents.

SCDSS spoke to law enforcement regarding the joint investigation. Detectives went to the hospital and spoke with the parents. Law enforcement also went to the home to take photographs. Law enforcement informed SCDSS that based on interviews with the parents there were no concerns for any criminality. It was likely the subject child suffocated after the parents put the child to sleep between them and covered him with a blanket. The subject child was found with a blanket over his face. Law enforcement's investigation would remain pending the final autopsy report.

SCDSS contacted the medical examiner to obtain updates on the autopsy throughout the investigation. The medical examiner reported that the autopsy remained pending further studies. SCDSS discussed concerns for suffocation as it was reported by law enforcement and the subject father that the subject child was found with a blanket over his face. The medical examiner reported the information she collected was that the blanket was pulled up to the subject child's shoulders and not covering the subject child's face. The medical examiners biggest concern was that the subject child was found in an adult bed sleeping between two adults. The medical examiner found nothing in the medical exam that indicated that the subject child was suffocated by the blanket. There was no indication in the preliminary autopsy of any abuse or maltreatment. The medical examiner reported that the cause and manner of death were pending further studies at the time of this writing.

SCDSS conducted a thorough investigation. SCDSS appropriately substantiated the allegations of DOA/Fatality and Inadequate Guardianship against the parents regarding the subject child. Despite their knowledge of safe sleep procedure and having the appropriate sleep space for the subject child, the parents practiced bedsharing on a regular basis. Bereavement services were discussed with the family for the parents, surviving siblings and extended family. The family declined services; however, discussed utilizing these services in the future.

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? Yes

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

Explain:
The decision to close the case was appropriate.

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: 05/18/2025 **Time of Death:** 06:59 PM

County where fatality incident occurred: Suffolk

Was 911 or local emergency number called? Yes

Time of Call: 06:08 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? N/A
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	27 Day(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	29 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	29 Year(s)
Deceased Child's Household	Sibling	No Role	Female	8 Year(s)
Deceased Child's Household	Sibling	No Role	Male	8 Year(s)

LDSS Response

On 05/18/2025, SCDSS received a report regarding the death of the 3-week-old SC. SCDSS initiated their investigation within 24 hours, completed a CPS history check which revealed no prior indicated history. SCDSS contacted LE, the ME, the source of the report, and the DA. SCDSS interviewed the parents and family members in the home. SCDSS interviewed the SS's and completed a 24-hour-safety assessment.

SCDSS interviewed the SM regarding the events leading to the fatal incident. The SM reported on 05/17/2025, she stayed home with the SC while the SF dropped the SS1 at his BF's home. The other SS2 had been picked up by her BM before the SF left. Neither SS was at the home at the time of the fatal incident. The SM reported she fed the SC and changed his diaper around 9:00pm. The SF arrived home around 9:30-10pm. The SC fell asleep between them on their bed. The SM and the SF were awake until about 12:30am. The SM heard the SC wake around 2:30am, the SF fed him a bottle while she continued to sleep. She was awakened at 6:00am by the SF who said the SC was not responsive. The SF was holding the SC at the foot of the bed. The SM screamed and tried to wake the SC while the SF contacted 911. The grandmother and aunt that lived upstairs woke and came into the room. The aunt administered cardiopulmonary resuscitation (CPR) until police and ambulance arrived. They transported the SC to a Community Hospital via ambulance.

The SF reported that on the evening of 5/17/25, he arrived home around 9:30pm. The SM and SC were awake and lying on the adult bed. Eventually, the SC fell asleep. He could not recall whether they placed him in the bassinet or their bed. The SM and SF fell asleep around 12:30am. The SC woke around 2:30am for a feeding. The SF fed the child a bottle and placed him in the bed between him and the SM. He laid the child face up below the pillows. He covered the SC, and the

SC slept with his own blanket. The SF and SM each sleep with their own blankets and placed another blanket over the three of them. The SF slept against the wall and the SM slept on the opposite side of the bed. The SF woke around 6:00am and checked on the SC. The SF observed the child face up in the middle of the bed below the pillows with a blanket over his face. He lowered the blanket and touched the SC's face. The SC looked normal and appeared to be sleeping. The SF became concerned that the SC did not move or respond to his touch. He lifted the SC from the bed, but the SC did not wake and was not breathing. He woke the SM who began screaming. He called 911 who instructed him to perform cardiopulmonary resuscitation. The SF reported he was aware of the risks of bed sharing.

SCDSS interviewed family members, and they corroborated the parent's timeline of events leading to the fatal incident and reported no concerns for the parent's care of the children. The family corroborated the parents' timeline of events the morning of the fatal incident. SCDSS contacted the SS's schools, SC's physician and hospital staff as collaterals. SCDSS completed all safety and risk assessments accurately and closed their investigation timely. There were no concerns for drug or alcohol misuse in the home and safe sleep recommendations were discussed with the family throughout the investigation.

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: Suffolk County does not have an approved OCFS Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
072214 - Deceased Child, Male, 27 Day(s)	072215 - Mother, Female, 29 Year(s)	DOA / Fatality	Substantiated
072214 - Deceased Child, Male, 27 Day(s)	072215 - Mother, Female, 29 Year(s)	Inadequate Guardianship	Substantiated
072214 - Deceased Child, Male, 27 Day(s)	072216 - Father, Male, 29 Year(s)	DOA / Fatality	Substantiated
072214 - Deceased Child, Male, 27 Day(s)	072216 - Father, Male, 29 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:
SCDSS offered the parent's bereavement services on behalf of the SSs; however, the family was utilizing school counseling as well as family support. SCDSS provided the parents with literature regarding bereavement for the children. The parent's accepted the literature.

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 parents were offered bereavement services. The parents accepted the referral resources to utilize in the future.

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? N/A

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
☐ With fetal alcohol effects or syndrome
☐ Exhibiting withdrawal symptoms
☒ With none of the issues listed noted in case record

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
08/16/2025	Sibling, Male, 7 Years	Other - ex partner, Male, 27 Years	Inadequate Guardianship	Unsubstantiated	Yes

Report Summary:
On 8/15/23, at about 5:30pm, the ex-parent substitute arrived at the home of the mother uninvited and unannounced and became angry when he saw the mother with her new boyfriend. The ex-parent substitute went to his car, grabbed a machete and proceeded to swing it at the vehicle that the mother and 7-year-old SS were in.

Report Determination: Unfounded | **Date of Determination:** 09/13/2023

Basis for Determination:
The ex-parent substitute was deemed not a person legally responsible for the child and the case was closed as unfounded.

OCFS Review Results:
The investigation was initiated timely, a CPS history check was completed, and the source of the report was contacted. The 7-day safety assessment was completed accurately and timely. The family was interviewed, and collaterals were contacted. The subject of the report was not contacted; however multiple attempts were made to interview him regarding the allegations. There was an OP issued against the ex-parent substitute regarding the SM and SS. The decision to close the case as unfounded was appropriate. SCDSS did not add the BF to the investigation, notify him or interview him.

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

Issue:
Adequacy of face-to-face contacts with the child and/or child's parents or guardians

Summary:
SCDSS did not add the BF of the SS to the report as a parent or notify him about the investigation. There was no documentation that the BF was interviewed.

Legal Reference:
18 NYCRR 432.1 (o)

Action:
SCDSS will make casework contacts per the following regulation: Casework contacts mean face-to-face contacts with a child and/or a child's parents or guardians, or activities with the child and/or the child's parents or guardians, which may include but are not limited to facilitating information gathering and analysis of safety and risk factors and determining the allegations.

PIP Requirement:
For citations identified in historical cases, SCDSS will submit a PIP to the Westchester Regional Office within 30 days of receipt of this report. The PIP will identify action(s) SCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, SCDSS will review the plan and revise as needed to address ongoing concerns.

CPS - Investigative History More Than Three Years Prior to the Fatality

Investigation opened 5/25/2021, and closed 8/30/2021, with allegations of IG and PD/AM against the SM, grandmother and OA regarding the SS were unsubstantiated.

Investigation opened10/17/2020, and closed 11/30/2020, with allegations of IG and LS regarding the SS were substantiated against the babysitter/friend as it could be shown that the physical, mental, emotional condition of the child was placed at risk of impairment by her actions. The SM left the SS in the care of another person who then left the SS alone.

Investigation opened 2/04/2020, and closed 4/01/2020, with allegations of IG and LS against the BF of the SS and the OA regarding the SS and OC was unfounded. There was no evidence that the children were left alone.

Investigation opened 11/01/2019, closed 12/23/2019, with allegations of IG and PD/AM against the BF of the SS, OA (mother to OC) and the grandmother regarding the SS and OC were unsubstantiated.

Investigation opened 10/04/2019, closed 10/29/2, with allegation of IG against the OA and the BF of the SS regarding the SS and OC were unsubstantiated.

Investigation opened 9/23/2019, closed 10/22/2019, with allegations of IG and L/B/W against the SM and PS at the time regarding the SS were unsubstantiated.

Investigation opened 6/05/2018, closed 9/17/2018, with allegation of IG against the BF of the SS and the OA regarding the OC were unsubstantiated.

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