Office of Children and Family Services

Child Fatality Report

Report Identification Number: SV-25-031

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

Issue Date: Sep 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: 4 month(s)
Jurisdiction: Westchester
Gender: Male
Date of Death: 06/21/2025
Initial Date OCFS Notified: 06/21/2025

Presenting Information

An SCR report was received that alleged around 10:30AM on 6/21/25, the mother and the father placed the 4-month-old alone in the crib with a pillow in it to nap. As a result, when the mother and the father checked on the child at 1:30PM, he was face down in the crib under a pillow and was not breathing. The parents immediately called 911. The father and an unknown adult left the home with the child at 1:45PM and arrived at the hospital at 1:55PM. Upon arrival, the child was unresponsive, pale, limp, and blue around the mouth. Despite cardiopulmonary resuscitation (CPR) and administering epinephrine, dextrose, and bicarbonate, the child was pronounced deceased at 2:50PM. The unsafe sleep environment may contributed to the child's death.

Executive Summary

This report concerns the death of a 4-month-old male child. Westchester County Department of Social Services (WCDSS) received an SCR report regarding the child's death on 6/21/25. The report contained allegations of DOA/Fatality, Inadequate Guardianship, and Lack of Medical Care. At the time of the child's death, he resided at home with his mother, father, adult cousin, and 11 surviving siblings, ages 20, 18, 16, 15, 12, 10, 8, 7, 5, 4, and 2-years-old.

On the morning of 6/21/25 at approximately 10:30AM, the child became fussy, and the father fed him, burped him, then rocked him in a rocking chair until he fell asleep. The father placed the child on his back on the adult bed with a large C-shaped pillow on one side of the child and a smaller pillow on the other side of the child, to prevent him from rolling off the bed. The father brought the baby monitor to the mother in the kitchen area of the home. At approximately 1:45AM, the mother entered the bedroom to check on the child, and she found him face down on the bed, unresponsive. The mother contacted 911; however, the father and 18-year-old adult sibling drove the child to the hospital. The father started Cardiopulmonary Resuscitation on his way to the hospital. Despite life-saving measures being continued at the hospital, the child was pronounced deceased at 2:50PM.

The medical examiner was notified and performed an autopsy on the child. The final cause and manner of death were pending at the time the CPS investigation was closed. Preliminary findings were asphyxia due to unsafe sleep on an adult bed with a bed topper. Law enforcement did not find any injury to the child, nor was abuse or neglect by the parents suspected. Law enforcement had not made any arrests, and their investigation remained open, pending the final autopsy report.

Multiple home visits were made to the family residence, and the surviving siblings were interviewed and assessed to be safe in the care of the parents.

WCDSS determined that the family did have the appropriate sleeping arrangements for the child; however, the father demonstrated poor judgment by placing the child to sleep in the adult bed with pillows around the child. The mother confirmed that she observed the child on the bed when she entered the room on multiple occasions. WCDSS substantiated the allegations related to the fatality.

The mother was engaged in counseling before the death of the subject child. Bereavement services were offered to the entire family. At the close of the CPS investigation, services were being offered to the family.

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:
WCDSS made the appropriate decision to substantiate the allegations of DOA/Fatality and Inadequate Guardianship against the SM and SF regarding the SC, and unsubstantiate the allegation of Lack of Medical Care.

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:
There was detailed documentation of supervisory consult and case planning throughout the investigation.

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

Child Fatality Report

Date of Death: 06/21/2025 **Time of Death:** 02:50 PM

Time of fatal incident, if different than time of death: 01:30 PM

County where fatality incident occurred: Westchester
Was 911 or local emergency number called? Yes
Time of Call: Unknown
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: 01
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	4 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	47 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	38 Year(s)
Deceased Child's Household	Other Adult - cousin to SC	No Role	Male	47 Year(s)
Deceased Child's Household	Sibling	No Role	Female	18 Year(s)
Deceased Child's Household	Sibling	No Role	Female	15 Year(s)
Deceased Child's Household	Sibling	No Role	Male	12 Year(s)
Deceased Child's Household	Sibling	No Role	Female	10 Year(s)
Deceased Child's Household	Sibling	No Role	Male	8 Year(s)
Deceased Child's Household	Sibling	No Role	Male	7 Year(s)
Deceased Child's Household	Sibling	No Role	Female	5 Year(s)
Deceased Child's Household	Sibling	No Role	Female	4 Year(s)
Deceased Child's Household	Sibling	No Role	Male	20 Year(s)
Deceased Child's Household	Sibling	No Role	Female	16 Year(s)
Deceased Child's Household	Sibling	No Role	Female	2 Year(s)

LDSS Response

On 6/21/25, WCDSS received a report regarding the death of a 4-month-old SC. WCDSS initiated their investigation within 24 hours and coordinated their efforts with law enforcement. WCDSS contacted the source of the report, completed a CPS history check regarding the family, and informed the DA of the fatality. WCDSS assessed the safety of the SSs and conducted multiple home visits throughout the investigation.

WCDSS completed an array of interviews with the parents, relatives, and pertinent collaterals. All those interviewed presented a timeline and description of events that did not differ from the parents' account of the incident. The night before, the child went to sleep around 8:00PM, after being nursed and bathed. The father took over caretaking responsibilities at the time so that the mother could get a good night's rest. The mother woke the following morning around 5:30AM to feed the dogs and make coffee. Around 6:45AM, the child was nursed by the mother and went back to sleep in his crib. The child woke again at 9:30AM. At that time, the father cared for the child so the mother could make breakfast and get lunches ready for the day. The father brought the child upstairs at 10:30AM for his morning nap. The father laid the child on the adult bed with a C-shaped pillow on one side of him and a "regular" pillow on the other side of him. According to the parents, this was to prevent the child from rolling off the bed. The mother was in and out of the room, getting some of the younger siblings ready for their dance recital. She did not observe the child to be in any distress. The mother entered the bedroom again around 1:30PM to check on the child because the last time he was fed was 10:30AM. When the mother entered the room, the child was on his belly with his head to one side and purple in color. The mother picked the child up and ran out of the room. The 18-year-old sibling was there and grabbed the child from the mother. The father entered the home, and he and the 18-year-old surviving sibling transported the child to the hospital. The mother remained home and contacted 911.

The parents reported that the child was given two vaccines and had a slight fever the day prior to the fatal incident. WCDSS received pediatric records for the child, which reflected that he was up to date medically, and there were no medical concerns. The parents stated that they were aware of safe sleep practices; however, would allow the child to sleep in the adult bed, the rocker, carriage, or crib.

WCDSS interviewed the 20, 18, 16, 15, 12, 10, 8, 7, and 5-year-old surviving siblings. The surviving siblings were assessed to be safe in the care of the parents. Some of the surviving siblings were unaware of what occurred on the day of the fatality, while others corroborated the information provided by the parents.

WCDSS contacted numerous collateral sources, including the school, medical staff, law enforcement, the pediatrician, day care provider, and the medical examiner. At the close of the investigation, the SSs were deemed as safe, and no criminal charges were brought against either parent.

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
072102 - Deceased Child, Male, 4 Month(s)	072103 - Mother, Female, 38 Year(s)	Lack of Medical Care	Unsubstantiated
072102 - Deceased Child, Male, 4 Month(s)	072104 - Father, Male, 47 Year(s)	Lack of Medical Care	Unsubstantiated
072102 - Deceased Child, Male, 4 Month(s)	072103 - Mother, Female, 38 Year(s)	DOA / Fatality	Substantiated
072102 - Deceased Child, Male, 4 Month(s)	072103 - Mother, Female, 38 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
072102 - Deceased Child, Male, 4 Month(s)	072104 - Father, Male, 47 Year(s)	DOA / Fatality	Substantiated
072102 - Deceased Child, Male, 4 Month(s)	072104 - Father, Male, 47 Year(s)	Inadequate Food / Clothing / Shelter	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	☒	☐	☐	☐

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	☐	☐	☐	☐	☐	☒

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
06/04/2023	Sibling, Female, 15 Years	Father, Male, 44 Years	Inadequate Guardianship	Unsubstantiated	No

Report Summary:
The SCR report stated that on 6/4/23, the mother and father were arguing about the then 15-year-old SS cleaning her room. This escalated when the father threw an unknown object at the mother in the immediate presence of the 15-year-old SS. The child was not injured.

Report Determination: Unfounded | **Date of Determination:** 08/21/2023

Basis for Determination:
WCDSS interviewed all family members and relative collaterals. The mother admitted to arguing with the father in the presence of the 15-year-old SS and contacting law enforcement. She stated that she overreacted by contacting law enforcement in this situation. Interviews with the other children revealed that they did not witness physical altercations with the parents and reported feeling safe in the home with the parents.

OCFS Review Results:
The investigation was initiated timely, the source of the report was contacted, and written notice of the report was provided in a timely manner. Interviews with the family and collateral contacts were appropriate. The 7-day Safety Assessment was completed timely and accurately.

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

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

10/19 - 2/20 The BM and BF were unsubstantiated for IG and L/B/W regarding one of the SSs.

Known CPS History Outside of NYS

There is no known CPS history outside of New York 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