Child Fatality Report

Report Identification Number: SV-25-032

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

Issue Date: Oct 21, 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: 2 month(s)
Jurisdiction: Suffolk
Gender: Male
Date of Death: 06/25/2025
Initial Date OCFS Notified: 06/25/2025

Presenting Information

An SCR report alleged on 6/25/25, the mother fed the subject child between 5:00-6:00AM before placing him into bed with her, the father, and the 3 surviving siblings. The father woke around 8:40AM, and found the subject child unresponsive and not breathing under the mother's leg. The father brought the subject child to the couch, contacted 911, and performed CPR until EMS arrived. Upon arrival, EMS took over life-saving measures and transported the subject child to the hospital where he was pronounced deceased.

Executive Summary

This report concerns the death of the 2-month-old subject child that occurred on 6/25/25. Suffolk County Department of Social Services (SCDSS) received an SCR report regarding the child's death on that date. At the time of his death, the subject child resided with his mother, father, 2-month-old surviving sibling, and two half siblings ages 8 and 3.

At approximately 5:00AM on 6/25/25, the mother fed the subject child and placed him into the bed with her and the 2-month-old surviving sibling. At around 8:40AM, the father, who had slept on the couch to give the mother, SC, and SS more space to sleep, entered the bedroom and observed the mother's leg on top of the subject child. The father moved the mother's leg, waking her, and found the subject child was not moving or responsive. The father brought the subject child into the living room where the mother started CPR, and the father contacted 911. When he hung up the phone, the father took over CPR until EMS arrived and transported the subject child to the hospital where he was pronounced deceased.

SCDSS made several home visits and interviewed the mother, father, the 8-year-old surviving sibling, and the surviving sibling's biological fathers. The 3-year-old surviving sibling was not interviewed due to developmental limitations. SCDSS discussed safe sleep guidelines with all caregivers during each home visit. All siblings were assessed as safe.

The medical examiner was notified and performed an autopsy of the child. The cause and manner of death were pending the final autopsy report which had not been received by the close of the investigation. There were no signs of trauma observed on the subject child. Law enforcement was notified and began an investigation. There were no arrests made, and the criminal investigation remained open pending the final autopsy results.

SCDSS found a fair preponderance of evidence and made the appropriate determination to substantiate the allegations of Inadequate Guardianship against the mother and father. However, it was learned during the CPS investigation that the father was aware of the mother bed-sharing with the subject child and surviving sibling and he knowingly left the bedroom to sleep in the living room. Additionally, the mother and father expressed awareness of safe-sleep guidelines; however, SCDSS did not add/substantiate allegations of Inadequate Guardianship against the mother and father in regard to the 2-month-old surviving sibling who was also placed in imminent danger of harm.

The mother and father accepted bereavement services for themselves and the 8-year-old surviving sibling. The case was indicated and closed timely on 8/14/25.

PIP Requirement

SCDSS will submit a PIP to the Westchester Regional Office within 30 days of receipt of this report. The PIP will identify action(s) the 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.

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?** No

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** No, sufficient information was gathered to determine some allegations only.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
SCDSS appropriately determined the allegations listed in the SCR report; however, during the investigation it was learned that the SC and the 2-month-old SS were intermittently bed sharing with the SM, which included the night of the fatal incident. Despite this information, there were no allegations of Inadequate Guardianship added against the SM and SF regarding the SS.

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:
Casework activity was commensurate with the case circumstances.

Required Actions Related to the Fatality

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

Issue:	Pre-Determination/Nature, Extent and Cause of Any Condition

Summary:	During the CPS investigation it was discovered the SM was bed-sharing with SC and the 2-month-old SS; however, there were no allegations of Inadequate Guardianship added/substantiated against the SM and SF.
Legal Reference:	18 NYCRR 432.2(b)(3)(iii)(c)
Action:	SCDSS will make an adequate assessment of the nature, extent and cause of any condition which may constitute abuse or maltreatment, whether contained in the original SCR report or discovered during the open investigation.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/25/2025 **Time of Death:** 09:46 AM

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

County where fatality incident occurred: Suffolk
Was 911 or local emergency number called? Yes
Time of Call: 08:47 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	Male	2 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	28 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	28 Year(s)
Deceased Child's Household	Sibling	No Role	Female	3 Year(s)
Deceased Child's Household	Sibling	No Role	Female	2 Month(s)

Deceased Child's Household	Sibling	No Role	Female	8 Year(s)

LDSS Response

On 6/25/25, SCDSS received a report regarding the death of the subject child. SCDSS initiated their investigation within 24 hours, coordinated efforts with law enforcement, contacted the source of the report, completed a CPS history check of the family, and conducted home visits to assess the safety of the surviving siblings.

SCDSS interviewed all adults regarding the events leading up to the SC's death, and a timeline of the incident was provided by the mother and father. The mother and father were interviewed and stated the day before the fatal incident the SC and the 2-month-old SS had received immunizations at the pediatrician. That evening, the SC was fussier than usual, and the SC and the SS were brought into the mother and father's bed to sleep. The father wanted to give them more space and went to sleep in the living room. The mother, SC, and SS slept in an "F" position; the mother's head was at the top of the bed, the SC had his head near the mother's breast with his feet at the side edge of the bed. The SS's feet were near the mother's hip, and her head was at the side edge of the bed. The mother gave the SC a bottle at approximately 5:00AM and placed him in the same position. The father woke around 8:40AM and entered the bedroom to find the mother's leg on top of the SC. The father pushed the mother's leg off the SC, which woke her. The father stated the SC was not moving and he was cooler than the SS. The mother started CPR and the father called 911. The father took over CPR when he ended the call because the mother was panicking. When EMS arrived, they took over CPR and transported the SC to the hospital. The mother and father were aware of safe sleep guidelines, and there were separate bassinettes present in the mother and father's bedroom for the SC and 2-month-old SS. The mother and father stated they bed-shared from time to time; however, they were unable to say how often.

The 8-year-old SS was not at the case address when the incident occurred as she was at her biological father's home for a visit. When interviewed, she did not reveal any safety concerns in either parent's home. There were no attempts to interview the 3-year-old SS, who was present and asleep during the incident, due to a diagnosed developmental disability. The SSs were free of any visible marks/bruises and were assessed as safe. The biological fathers of the 8 and 3-year-old SSs were interviewed; there were no safety concerns shared.

SCDSS interviewed several collateral sources, including the pediatrician, hospital, family members, the school, and LE. There were no concerns shared. SCDSS offered the mother, father, and 8-year-old SS bereavement services, which were accepted. Additionally, SCDSS assisted with obtaining school supplies for the school aged SSs. SCDSS indicated and closed the case.

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

Child Fatality Report

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
071552 - Deceased Child, Male, 2 Month(s)	071553 - Mother, Female, 28 Year(s)	DOA / Fatality	Substantiated
071552 - Deceased Child, Male, 2 Month(s)	071553 - Mother, Female, 28 Year(s)	Inadequate Guardianship	Substantiated
071552 - Deceased Child, Male, 2 Month(s)	071554 - Father, Male, 28 Year(s)	DOA / Fatality	Unsubstantiated
071552 - Deceased Child, Male, 2 Month(s)	071554 - Father, Male, 28 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	☒	☐	☐	☐

Explain:
SCDSS offered the family appropriate referrals in response to the fatality. The RAP was incorrectly scored 'no' for the caretaker having been a victim of domestic violence despite documentation stating there was a current Order of Protection in place between the SM and the 3yo SS's biological father. If scored correctly, the risk rating would not change.

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	☒	☐	☐	☐	☐	☐

Other, specify: Medical care management

Additional information, if necessary:
SCDSS provided all family members with all appropriate referrals. Additionally, SCDSS assisted the family with obtaining school supplies for the SSs.

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 resources were offered on behalf of the 8-year-old surviving sibling.

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 referrals and burial assistance were offered to the caregivers in response to the fatality.

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)
07/12/2024	Sibling, Female, 7 Years	Mother, Female, 27 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	Yes
	Sibling, Female, 2 Years	Mother, Female, 27 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	

Report Summary:
An SCR report alleged the SM, and the then 7- and 2-year-old SSs lived in a room within a home that appeared to be condemned. The home was dirty and dark, and the room they resided in had no window, air conditioning, or fan. On 7/1/24, a rodent was present in the room and the 2-year-old SS almost grabbed it by the tail. The SM was aware of the conditions and made no efforts to fix the issues.

Report Determination: Unfounded	**Date of Determination:** 09/10/2024

Basis for Determination:
There was not a fair preponderance of evidence obtained to demonstrate the physical, mental, or emotional condition of the SSs were being placed at risk of harm by the SM's actions. The home was found to be above the minimum degree of care, and the SSs were observed to be well cared for and free of visible marks/bruises. There was no evidence of an infestation of any kind present in the home.

OCFS Review Results:
Documentation was detailed and contained pertinent information. SCDSS conducted full interviews of the biological fathers of the SSs, provided items and an abundance of information for local resources to the family. Approximately half of the notes present in the case record were entered between 5-8 weeks after the event date.

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

Issue:

Timely/Adequate Case Recording/Progress Notes

Summary:

Approximately 30 out of 53 progress notes were not entered contemporaneously during the CPS investigation, and were documented between 5 and 8 weeks after the event date.

Legal Reference:

18 NYCRR 428.5

Action:

Progress notes must be made as contemporaneously as possible with the occurrence of the event or the receipt of the information which is to be recorded.

[redacted]

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

In 2019, the SM was listed on a report with the MGM and the MGM's husband. The SCR report contained allegations of PD/AM and IG in regard to the then 2-year-old SS and the then 9-month-old maternal uncle. The case was unfounded and closed due to a lack of evidence.

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