Child Fatality Report

Report Identification Number: SV-25-033

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: 5 month(s)
Jurisdiction: Westchester
Gender: Female
Date of Death: 07/07/2025
Initial Date OCFS Notified: 07/07/2025

Presenting Information

Two SCR reports were received on 7/7/25, which alleged, at either at 12:00AM or 12:30AM, the mother and father placed the subject child to sleep in their bed, and the parents then fell asleep in the same bed. The parents woke at 4:00AM to find the child face-down in the bed and unresponsive. The parents called 911 at 4:15AM and the mother was walked through performing cardiopulmonary resuscitation (CPR). Law enforcement and emergency medical services (EMS) responded and performed CPR on the child during transport via ambulance. The child arrived at the hospital where CPR and life-saving measures continued until the child was pronounced deceased. It was alleged that the unsafe sleep arrangement contributed to the death.

Executive Summary

This report concerns the death of the 5-month-old female subject child. The Westchester County Department of Social Services (WCDSS) received two SCR reports regarding the child's death on 7/7/25. At the time of the child's death, she resided with her mother, father, 12-year-old sibling, and 5-month-old twin sibling.

On the evening of 7/5/25, the mother noticed the subject child and twin sibling had flushed cheeks, and by the evening of 7/6/25, the mother noticed multiple blisters on the child's toes, indicative of a common childhood virus. The child typically sucked her thumb; however, she was not doing so, and the mother noticed a blister on her thumb as well. The mother did not take the child to the emergency room or pediatrician at that time as she believed the child had contracted the virus from a visiting half-sibling who had recently tested positive. The mother provided children's Tylenol and Motrin to manage symptoms. The child ate very little that day (7/6/25) and had her last bottle around 8:00PM, was burped, and placed down for "tummy time." When the child fell asleep, she was moved to the parents' bed and placed on top of a receiving blanket in the middle of the queen-sized bed, on her side. The parents went to sleep on either side of the child. At 12:41AM, the mother woke and checked on the subject child, twin, and 12-year-old sibling. Around 4:00AM, the parents woke to the smell of feces in the bed. The child was cold to the touch at that time and appeared pale in color. The father immediately called 911 while the mother began CPR and chest compressions. Upon EMS arrival, the child was pulseless, apneic, and her skin was pale, cool, and mottled. The child remained asystole throughout transport and pronounced dead in the emergency department.

The medical examiner was notified and performed an autopsy on the child. The cause of death was "asphyxia of a 5-month-old infant due to unsafe sleeping in [an] adult bed with parents." The manner of death was accidental. Law enforcement investigated and no arrests had been made regarding the death of the child.

WCDSS made several home visits and interviewed the parents and the elder sibling residing in the home. The siblings residing in the home were assessed to be safe. The father had two additional children residing outside the home who visited. One half-sibling's mother denied WCDSS access to interview that child. The other half-sibling was assessed virtually with no concerns.

WCDSS made the appropriate determination to substantiate the allegations of Inadequate Guardianship and DOA/Fatality against the parents regarding the death of the child. WCDSS found that the parents failed to exercise a minimum degree of care by bedsharing with the child. The child was placed in the middle of an adult-sized bed, with both parents on either

side of the child. While there was a bedside bassinet available to the child and was the child's usual sleeping space, due to the child's perceived illness, the parents kept the child in their bed. The child was found face-down in the bed, consistent with the cause of death. The medical examiner concluded the unsafe sleep conditions caused the death, and a consultation with the Child Advocacy Center pediatrician indicated that the virus, which the child did test positive for, would not cause death.

The parents were offered and accepted bereavement services.

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:
WCDSS initiated their investigation timely, relevant collateral sources were spoken to, safety was assessed through consistent home visits, all required documentation was completed, and the investigation was determined accurately and timely.

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: 07/07/2025 **Time of Death:** 05:31 AM

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

County where fatality incident occurred: Westchester
Was 911 or local emergency number called? Yes
Time of Call: 04:15 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? No
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	5 Month(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	49 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	38 Year(s)
Deceased Child's Household	Sibling	No Role	Male	5 Month(s)
Deceased Child's Household	Sibling	No Role	Female	12 Year(s)

LDSS Response

On 7/7/25, WCDSS received two SCR reports regarding the death of the subject child. WCDSS initiated their investigation within 24 hours and coordinated their efforts with law enforcement, who had already interviewed the parents prior to WCDSS involvement. WCDSS contacted the sources of both reports, completed a CPS history check regarding the family, which revealed no prior child welfare history, and informed the DA of the fatality. WCDSS assessed the safety of the siblings, conducted a virtual visit on 7/7/25 (per the family's wishes) and completed a home visit on 7/9/25.

WCDSS interviewed the parents regarding the events leading up to the child's death. On 7/5/25, the mother noticed the twin sibling had "rosy cheeks" and thought it was a reaction to introducing sweet potato the day prior; however, when the

subject child developed rosy cheeks as well and had not tried sweet potato, the mother surmised the child had contracted a virus. The father's 10yo child had been visiting the home a few days prior, and the parents had been informed on 7/3/25 that child tested positive for a virus. The subject child became feverish and irritable by 7/6/25, and the mother administered Tylenol and Motrin on a rotating basis. At that time, the mother noticed the telltale blisters indicative of the virus on the child's toes and later her mouth when the mother noted the child was not eating her normal amount. The child was last fed around 8:00PM on 7/6/25, burped, and placed down on a pillow for tummy time. Typically, the child slept in a bedside bassinet as she would normally wake throughout the night. But on the evening of 7/6/25, "I saw the blisters…I know my baby wasn't feeling good and that's why I put her in the bed with us," the mother recalled, and the child was placed in the middle of the parents' queen-sized bed, on a receiving blanket. Although the parents denied blankets were present, photographs taken of the parents' bed show multiple standard-sized pillows, a pregnancy pillow, the receiving blanket, and a comforter. The child fell asleep around 11:00PM, the mother checked on her at 12:41AM and again at 4:00AM, when the child was found cold and unresponsive.

WCDSS interviewed the 12yo sibling who resided in the home, who reported the subject child always slept in her bassinet, and the twin never slept in the parents' bed. The father's 14yo child who frequently visited reported no concerns. The mother of the father's 10yo child, who had visited just prior to the fatality, refused to participate in the investigation. Safe sleep guidance was routinely reviewed with the parents regarding the surviving twin, and the twin had safe sleep accommodations.

WCDSS learned from the ME the cause of death was related to the unsafe sleeping conditions present. The ME confirmed the child did test positive for the suspected virus, and that virus could cause meningitis or encephalitis; however, there was no evidence of inflammation to indicate either condition was present. WCDSS consulted with the CAC pediatrician who stated the noted virus was not connected to the death. WCDSS assisted the family with having the siblings medically assessed and the twin was diagnosed with a mild case of the same virus. OCFS received the autopsy report which confirmed the cause of death to be asphyxia due to unsafe sleeping.

WCDSS contacted numerous collaterals in addition to the ME, including law enforcement, the sibling's school, family members, and the pediatrician. No medical concerns were noted for the child, other than birth at 31 weeks. WCDSS offered the family bereavement services, which they accepted. Additionally, WCDSS helped with diapers, clothing, and a backpack for the 12yo sibling. At the close of the investigation, the siblings were assessed as safe, and no criminal charges were brought against either parent. WCDSS did find evidence to support the allegations in the report and appropriately indicated the investigation.

Official Manner and Cause of Death

Official Manner: Accident

Primary Cause of Death: From an injury - external cause

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
072348 - Deceased Child, Female, 5 Month(s)	072351 - Mother, Female, 38 Year(s)	DOA / Fatality	Substantiated
072348 - Deceased Child, Female, 5 Month(s)	072351 - Mother, Female, 38 Year(s)	Inadequate Guardianship	Substantiated
072348 - Deceased Child, Female, 5 Month(s)	072352 - Father, Male, 49 Year(s)	DOA / Fatality	Substantiated
072348 - Deceased Child, Female, 5 Month(s)	072352 - Father, Male, 49 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?	☐	☒	☐	☐
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:

Although pediatric, prenatal, and birth records were obtained, ER records were not; however, records provided by EMS and the medical examiner were sufficient to support the determination and ER records would not likely provide new information.

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	☐	☐	☐	☐	☐	☒

Additional information, if necessary:
The family was referred to and initiated bereavement services. The mother was working with housing to move out of the family's current home due to that being the place of the fatal incident. WCDSS also assisted the family with diapers, clothing, and backpacks.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No

Was the child acutely ill during the two weeks before death? Yes

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 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