Child Fatality Report

Report Identification Number: SV-25-034

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

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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		

Child Fatality Report

Case Information

Report Type: Child Deceased
Age: 1 month(s)
Jurisdiction: Suffolk
Gender: Male
Date of Death: 07/08/2025
Initial Date OCFS Notified: 07/08/2025

Presenting Information

An SCR report was received which alleged that on 7/8/25, the mother woke up at 7:00AM and fed, burped, and changed the 1-month-old child. She then went back to bed and brought the child into bed. At 9:00AM, the mother awoke to find the child not breathing and called 911. When emergency medical services (EMS) arrived, they began cardiopulmonary resuscitation (CPR). They performed CPR for 25 minutes prior to getting to the hospital, where the child was pronounced deceased at 9:45AM. The mother's failure to ensure safe sleep may have resulted in the child's death.

Executive Summary

This report concerns the death of a 1-month-old male child, which occurred while in the care of his mother. Suffolk County Department of Social Services (SCDSS) received the SCR report regarding the child's death on 7/8/25. At the time of the child's death, he resided at home with his mother and surviving sibling.

On 7/8/25, the mother fed the child and placed him back to sleep with her in the adult bed. The mother went back to sleep alongside the child. The mother woke approximately 2 hours later and found the child unresponsive. The mother called 911 and was instructed to perform CPR until first responders arrived. The surviving sibling was at the paternal grandparents' house the day of the fatal incident.

The medical examiner was notified and performed an autopsy on the child. The cause and manner of death were pending at the close of the CPS investigation.

SCDSS made several home visits and assessed the safety of the surviving sibling. The surviving sibling was deemed safe in the care of the mother.

SCDSS made the appropriate decision to substantiate the allegations of Inadequate Guardianship and DOA/Fatality against the mother regarding the death of the subject child. During the investigation, it was learned that the mother failed to exercise a minimum degree of care by bedsharing with aggravating factors. At the time of the fatal incident, the mother laid the subject child on her left arm on the bed. There were two regular-sized pillows, two small pillows, a blanket, and a fitted sheet present. The record reflected that the room was hot, and the subject child was wearing sweatpants, a onesie, and a zip-up sweater. The Investigative Conclusion Narrative confirmed that, despite the mother being aware of unsafe sleep practices, she admits to engaging in bedsharing with the subject child. In addition, she acknowledged putting the infant to sleep in her bed, which contained aggravating factors leading to the death of the subject child.

The family was offered and accepted bereavement services and funeral assistance.

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:
SCDSS made the appropriate decision to substantiate the allegations of Inadequate Guardianship and DOA/Fatality based on information obtained throughout the investigation.

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

Date of Death: 07/08/2025 **Time of Death:** 09:46 AM

Time of fatal incident, if different than time of death: 09:00 AM

County where fatality incident occurred: Suffolk

Was 911 or local emergency number called? Yes
Time of Call: 09:04 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	1 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	22 Year(s)
Deceased Child's Household	Sibling	No Role	Female	11 Month(s)
Other Household 1	Father	No Role	Male	21 Year(s)

LDSS Response

On 7/8/25, SCDSS received a report regarding the death of the subject child. SCDSS initiated their investigation within 24 hours and coordinated their efforts with law enforcement. SCDSS contacted the source of the report, completed a CPS history check regarding the family, and informed the DA of the fatality. SCDSS assessed the safety of the SS and conducted an initial home visit the same day the report was received.

SCDSS interviewed all adults regarding the events leading up to SC's death. The mother confirmed that she lived in the home with the subject child and surviving sibling. She was home alone with the subject child the morning of the fatal incident, as the older sibling was with the paternal grandmother. The mother fed, burped, and changed the subject child between 6:00 and 7:00AM. He was placed back into the bassinet; however, the subject child was fussy and crying. The mother then placed the subject child in her left arm on the bed. The bed contained two regular-sized pillows, two small pillows, a fitted sheet, and a blanket. The room was described as being hot even though there was an air conditioner on. The mother woke around 8:50AM, and noticed that the subject child was under the blanket, looked pale, and was not breathing. She immediately contacted the paternal grandmother, who instructed her to call 911. She then contacted 911 and was instructed to begin CPR. The mother continued CPR until first responders arrived. The mother and child were transported to the hospital via ambulance, where the subject child was pronounced deceased.

The father confirmed that he did not reside with the mother and was not at the residence the morning of the fatal incident. He was with the subject child the night prior and had no concerns for the subject child or the care that the mother had provided.

SCDSS observed the SS; however, she was unable to be interviewed due to her age and development. The SS appeared free from visible marks and bruises and was assessed as safe on multiple occasions.

SCDSS contacted numerous collateral sources, including EMS, hospital physician, hospital social worker, pediatrician, and law enforcement. Services were offered to the family, and they were accepted. The mother engaged in mental health counseling. At the close of the investigation, the SS was deemed safe.

Law enforcement reported no updates at the close of the CPS investigation. The autopsy report was still pending.

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
072509 - Deceased Child, Male, 1 Month(s)	072510 - Mother, Female, 22 Year(s)	DOA / Fatality	Substantiated
072509 - Deceased Child, Male, 1 Month(s)	072510 - Mother, Female, 22 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	☐	☐	☐	☐	☐	☒

History Prior to the Fatality

Child Information

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

Was the child acutely ill during the two weeks before death? No

Infants Under One Year Old

During pregnancy, mother:

- ☐ Had medical complications / infections
- ☐ Misused over-the-counter or prescription drugs
- ☐ Experienced domestic violence
- ☐ Had a positive toxicology at the time of delivery
- ☐ Used marijuana
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs
- ☐ Used prescription drugs
- ☒ Was not noted in the case record to have any of the issues listed

Infant was born:

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

CPS - Investigative History Three Years Prior to the Fatality

There is no CPS investigative history in NYS within three years prior to the fatality.

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

There was no CPS investigative history more than three years prior to the fatality.

Known CPS History Outside of NYS

There is no known CPS history outside of 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