Report Identification Number: NY-23-087

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

Issue Date: Mar 04, 2024

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 Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	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-Case Worker	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 **Jurisdiction:** New York **Date of Death:** 09/15/2023
Age: 1 year(s) **Gender:** Male **Initial Date OCFS Notified:** 09/15/2023

Presenting Information

New York City Administration of Children's Services (ACS) received three SCR reports that alleged on 9/15/23, the daycare provider placed the 1-year-old subject child, and three other children ages 2yo, 2yo, and 7-months-old down for a nap. When the daycare provider (DCP) attempted to wake the subject child and other children, they were all unresponsive. 911 was called and first responders arrived at the daycare. The children ingested an unknown substance while in the care of the daycare provider. The subject child was transported to the hospital, where he was pronounced deceased at 3:29pm on the same day. The subject child was an otherwise healthy child and the DCP had no explanation for the death. ACS received three subsequent SCR reports on 9/15/23 and 9/16/23, regarding the subject child and three other children at the daycare being exposed to fentanyl, became unresponsive, and were hospitalized.

Executive Summary

This report concerns the death of a 1-year-old male subject child, which occurred on 9/15/23. At the time of the subject child's death he and three other unrelated children were in the care of the daycare provider. The SCR report contained allegations of DOA/Fatality, Inadequate Guardianship, Lack of Supervision, Internal Injuries, and Poisoning/Noxious Substances against the daycare provider.

ACS learned the morning of 9/15/23, a provider was at the daycare from 9:00am until about 10:40am, and the subject child and other child 1 (OC1), other child 2(OC2), and other child 3(OC3) were observed to be playing and interacting with each other and the daycare provider. At about 12:50pm, other child 3 was picked up from the daycare by his mother, he was lethargic and unable to walk, and was later taken to the hospital by his mother. Sometime around 2:40pm, the subject child and other child 1 and 2, were found unresponsive by the daycare provider. 911 was called and law enforcement and emergency medical services (EMS) responded to the daycare. EMS began resuscitative measures on the subject child and transported him to the hospital. Upon arrival, hospital staff took over life saving measures; however, were unsuccessful and the subject child was pronounced deceased at 3:29pm. First responders found other child 1, and other child 2, at the daycare lethargic and one was in cardiac arrest. EMS began resuscitative measures and transported the two other children to the hospital. All three of the other children tested positive for Fentanyl and were admitted to the hospital.

The medical examiner was notified of the death and an autopsy was performed. The medical examiner listed the cause of death as acute fentanyl intoxication, and the manner of death was listed as homicide. The record reflected the daycare provider had fentanyl in a closet by the bathroom and a drug press machine in a bedroom closet that were both accessible to the children. Law enforcement investigated the death and the daycare provider was criminally charged with murder in the second degree 125.25(2), criminal possession of a controlled substance in the first degree 220.21(1), criminal possession of a controlled substance in the second degree 220.18(1), criminal possession of a controlled substance in the third degree 220.16(1), criminal possession of a controlled substance in the fourth degree 220.09(1) , manslaughter in the first degree 125.20(4), manslaughter in the second degree 125.15(1), and assault in the second degree 120.05(4). The day care provider was also charged with four counts of assault in the first degree 120.10(3), four counts of assault in the first degree 120.10(4), and four counts of endangering the welfare of a child 260.10(1). At the close of the CPS investigation the charges were pending in criminal court and the daycare provider remained incarcerated.

ACS indicated the allegations against the daycare provider for all the children. While consolidating the multiple subsequent reports, some allegations were not added to the fatality report regarding the subject child and other child 3.

The record did not reflect ACS met with the daycare provider or why the daycare provider was unable to be seen or interviewed, although the daycare provider was listed as the alleged subject on the report. The parents of the subject child declined to meet and speak with ACS, and ACS mailed bereavement resources to the family. The record did not reflect the subject child's parents were offered burial assistance.

PIP Requirement
ACS will submit a PIP to the New York City Regional Office within 45 days of the receipt of this report. The PIP will identify action(s) ACS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ACS 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:**
  - **Safety assessment due at the time of determination?** — N/A

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:
ACS made an appropriate determination based on the evidence obtained throughout the investigation. Safety and Risk Assessments are not required for daycare cases.

Was the decision to close the case appropriate? — Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? — No

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

Explain:
Casework activity was not commensurate with the case circumstance, the alleged subject was not interviewed regarding the report and allegations were not consolidated into the fatality report.

Required Actions Related to the Fatality

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:	The record did not reflect the daycare provider that was the alleged subject on the report was seen or interviewed by ACS, and there was no documentation as to why the daycare provider was not seen or interviewed.

Legal Reference:	18 NYCRR 432.1 (o)
Action:	ACS will make efforts to make face-to-face contact with all alleged subjects listed on the report and document efforts that were unsuccessful.
Issue:	Case record contains information that is relevant, useful, factual and objective
Summary:	ACS consolidated 3 subsequent reports into the fatality investigation and maintained two other separate reports. Although progress notes can be copied between investigations, maintaining separate records in this case led to fragmented case recording and missed allegations being consolidated into the fatality.
Legal Reference:	18 NYCRR 428.1(a) and 18 NYCRR 428.1(b)(1)
Action:	ACS records must contain information that is relevant, useful, factual, and objective to best reflect accuracy throughout documentation. Such information is pertinent to investigations and the review of service needs.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 09/15/2023 **Time of Death:** 03:29 PM

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

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? Yes
Time of Call: 02:41 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? Yes
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 Year(s)
Deceased Child's Household	Father	No Role	Male	44 Year(s)
Deceased Child's Household	Mother	No Role	Female	34 Year(s)

Other Household 1	Day Care Provider	Alleged Perpetrator	Female	36 Year(s)
Other Household 2	Other Child - OC1 daycare attendee	Alleged Victim	Male	2 Year(s)
Other Household 2	Other Child - OC2 daycare attendee	Alleged Victim	Female	7 Month(s)
Other Household 3	Other Child - OC3 daycare attendee	Alleged Victim	Male	2 Year(s)

LDSS Response

On 9/15/23, ACS received an SCR report regarding the death of the 1-year-old SC, that occurred on the same day. ACS initiated their investigation within 24 hours and learned LE was aware of the fatality and ACS notified the DA's office. ACS contacted the sources of the multiple reports, spoke with law enforcement, and completed a CPS history check regarding the DCP and the children that were at the daycare. ACS was unable to gain access to the daycare due to it being a crime scene. The record did not reflect ACS saw or interviewed the daycare provider.

On 9/15/23, ACS was unable to engage the SC's parents while at the hospital as they did not feel the need to discuss the reported concerns as they were more concerned about the well-being of the SC. ACS attempted to engage the SC's parents again on 9/19/23, during a home visit and through their attorney declined to meet and speak with ACS. ACS spoke with the parents of OC1, OC2, and OC3 that attended the daycare. OC1, OC2, and OC3 were seen; however, were unable to provide any information regarding the fatality due to their age and developmental ability. ACS conducted home visits with the parents of OC1 and OC2, and they were assessed safe with their parents. ACS conducted a home visit with the parents of OC3, and he was assessed safe with his parents.

ACS contacted collateral sources, including LE, hospital staff, OCFS Child Care Services, medical providers, and families attending the daycare. ACS spoke with hospital staff and confirmed that OC1, OC2, and OC3 all tested positive for Fentanyl. ACS learned the daycare had no previous violations and was last inspected on 9/6/23. The record reflected the daycare providers license was suspended and pending revocation as of 9/18/23. ACS mailed bereavement information to the SC's family. ACS found a preponderance of evidence to substantiate the allegations in the report and the case was indicated and closed.

Official Manner and Cause of Death

Official Manner: Homicide
Primary Cause of Death: From an injury - external cause
Person Declaring Official Manner and Cause of Death: Unknown

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: The New York City Administration of Children's Services does not have an OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
066349 - Deceased Child, Male, 1 Year(s)	066352 - Day Care Provider,	DOA / Fatality	Substantiated

	Female, 36 Year(s)		
066349 - Deceased Child, Male, 1 Year(s)	066352 - Day Care Provider, Female, 36 Year(s)	Inadequate Guardianship	Substantiated
066349 - Deceased Child, Male, 1 Year(s)	066352 - Day Care Provider, Female, 36 Year(s)	Lack of Supervision	Substantiated
066353 - Other Child - OC1 daycare attendee, Male, 2 Year(s)	066352 - Day Care Provider, Female, 36 Year(s)	Inadequate Guardianship	Substantiated
066353 - Other Child - OC1 daycare attendee, Male, 2 Year(s)	066352 - Day Care Provider, Female, 36 Year(s)	Internal Injuries	Substantiated
066353 - Other Child - OC1 daycare attendee, Male, 2 Year(s)	066352 - Day Care Provider, Female, 36 Year(s)	Lack of Supervision	Substantiated
066353 - Other Child - OC1 daycare attendee, Male, 2 Year(s)	066352 - Day Care Provider, Female, 36 Year(s)	Poisoning / Noxious Substances	Substantiated
066354 - Other Child - OC2 daycare attendee, Female, 7 Month(s)	066352 - Day Care Provider, Female, 36 Year(s)	Inadequate Guardianship	Substantiated
066354 - Other Child - OC2 daycare attendee, Female, 7 Month(s)	066352 - Day Care Provider, Female, 36 Year(s)	Internal Injuries	Substantiated
066354 - Other Child - OC2 daycare attendee, Female, 7 Month(s)	066352 - Day Care Provider, Female, 36 Year(s)	Lack of Supervision	Substantiated
066354 - Other Child - OC2 daycare attendee, Female, 7 Month(s)	066352 - Day Care Provider, Female, 36 Year(s)	Poisoning / Noxious Substances	Substantiated
066355 - Other Child - OC3 daycare attendee, Male, 2 Year(s)	066352 - Day Care Provider, Female, 36 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?	☒	☐	☐	☐

Additional information:

ACS was unable to gain entrance to the daycare due to the ongoing criminal investigation. The record did not reflect why

the daycare provider was unable to be interviewed. The parents of the SC declined to engage with ACS regarding the SC's death.

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?	☐	☐	☒	☐

Explain:
Safety Assessments are not required in daycare cases.

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:
The record reflected the parents of the subject child declined to engage with ACS and ACS mailed grief counseling resources to the parents.

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?

☐Family Court ☒Criminal Court ☐Order of Protection

Criminal Charge: Murder **Degree:** 2			
Date Charges Filed:	**Against Whom?**	**Date of Disposition:**	**Disposition:**
Unknown	the daycare provider	Pending	The case is still pending in criminal court.
Comments:	The DCP was also charged with criminal possession of a controlled substance in the first degree 220.21(1), criminal possession of a controlled substance in the second degree 220.18(1), criminal possession of a controlled substance in the third degree 220.16(1), criminal possession of a controlled substance in the fourth degree 220.09(1) , manslaughter in the first degree 125.20(4), manslaughter in the second degree 125.15(1), and assault in the second degree 120.05(4). The day care provider was also charged with four counts of assault in the first degree 120.10(3), of assault in the first degree 120.10(4), and endangering the welfare of a child 260.10(1).		

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
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	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
ACS mailed information on bereavement services to the parents prior to the close of the investigation. It was unknown if any of the services were utilized.

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

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 history outside of NYS.

Provider Oversight/Training

	Yes	No	N/A	Unable to Determine
Did the provider comply with discipline standards?	☐	☐	☐	☒

Was a Criminal History check conducted? **Date:**	☐	☐	☐	☒
Was a check completed through the State Central Register? **Date:**	☐	☐	☐	☒
Was a check completed through the Staff Exclusion List? **Date:**	☐	☐	☐	☒

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