Child Fatality Report

Report Identification Number: BU-18-035

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

Issue Date: May 06, 2019

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 has an open 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		
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	
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 day(s)
Jurisdiction: Erie
Gender: Female
Date of Death: 09/23/2009
Initial Date OCFS Notified: 12/02/2018

Presenting Information

An SCR report was made alleging that within the last 5 years the mother and father allowed an 11-year-old child to care for the 2-month-old deceased child, and the 11yo was not responsible enough for this role. Subsequently, the 11yo rolled on top of the baby, resulting in her death. There were further allegations that the father had a history of selling drugs from the home in the presence of the children in the home. It was unknown if the mother was aware of the drug activity.

Executive Summary

This report concerns the death of the 4-day-old female infant. The death of the infant occurred on 9/23/09, but Erie County Department of Social Services (ECDSS) received the SCR report concerning the fatality on 12/2/18.The household composition at the time of the infant's death was the mother, an adult sibling, the adult sibling's child, the 17yo sibling and 14yo sibling (then ages 8 and 5). The 7yo sibling was born after the death of the infant. ECDSS promptly assessed the safety of all the siblings.

ECDSS learned the infant died 4 days after she was born. The mother slept in the bed with the infant and other children on a regular basis. On the morning of 9/23/2009, the mother woke to find the 17yo sibling (then 8 years old) lying on top of the infant. The infant was lying face down in the mattress and was not breathing. The mother attempted CPR and contacted 911. First responders and ER staff were unable to resuscitate the infant.

An autopsy was completed and the ME report stated the manner of death was accidental and the cause of death was asphyxia due to overlay.

LE investigated the death in 2009 and made no arrest as no criminality was found. LE provided ECDSS with their reports from the incident, including statements from the mother and first responders. LE declined to investigate the fatality again.

ECDSS had a previous CPS investigation with the mother and surviving children that began on 11/20/2010, and the mother reported the death of the infant at that time. After initially learning of the infant's death, ECDSS contacted the ME and LE. ECDSS did not make an SCR report regarding the fatality at that time because they did not suspect abuse or neglect was a factor in the death. The guidance for CPS investigations of infant fatalities and injuries involving unsafe sleep conditions was issued in November of 2010.

ECDSS interviewed the mother, adult sibling, 17yo sibling, 14yo sibling and father during their investigation. ECDSS learned the father of the 17yo sibling was deceased. The father of the infant and the 7yo sibling was incarcerated since 2015 and had phone contact with the 7yo sibling. The father of the 14yo sibling had phone contact with him and was also interviewed.

ECDSS spoke with the sibling's schools and pediatricians, in addition to reviewing medical records. There were no concerns expressed to ECDSS regarding the care of the siblings by the mother.

ECDSS unsubstantiated the allegation of Inadequate Guardianship against the father regarding the 3 surviving children as he has been incarcerated since 2015 and there was no evidence he had access to the children since then. The allegation of DOA/Fatality was also appropriately unsubstantiated against the father regarding the infant, because he was not visiting or

living in the home at the time the incident occurred. The allegations of DOA/Fatality and Inadequate guardianship were substantiated against the mother. There was evidence that the unsafe sleeping conditions created a substantial risk to the infant and led to her death.

ECDSS spoke with the mother and siblings regarding services in reference to the fatality. ECDSS learned that the mother and children received counseling at the time of the death in 2009 and the family declined any further 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:
It was appropriate to conclude 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: 09/23/2009 **Time of Death:** Unknown

Time of fatal incident, if different than time of death: 06:00 AM

County where fatality incident occurred: Erie
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 alcohol or drugs? No
Child's activity at time of incident:

- ☒ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☐ Playing
- ☐ Eating
- ☐ Unknown
- ☐ Other

Did child have supervision at time of incident leading to death? Yes
At time of incident supervisor was:

- ☐ Drug Impaired
- ☐ Absent
- ☐ Alcohol Impaired
- ☒ Asleep
- ☐ Distracted
- ☐ Impaired by illness
- ☐ Impaired by disability
- ☐ 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	4 Day(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	37 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	34 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	8 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	5 Year(s)
Other Household 1	Other Adult - Father of 5yo SS	No Role	Male	35 Year(s)
Other Household 2	Other Adult - Father of 8yo SS	No Role	Male	33 Year(s)

LDSS Response

On 12/25/18, ECDSS received a report regarding the death of the infant. ECDSS contacted the source, LE, DA, ME and performed a CPS history check for the family. ECDSS made a home visit within 24 hours and assessed the safety of the surviving siblings (ages 17, 14 and 7). ECDSS deemed the children were safe in the care of the mother and learned the 7yo was not alive at the time of the infant's death in 2009.

ECDSS interviewed the mother and learned that on 9/22/09 the mother, infant, 17yo and 14yo siblings (then ages 8 and 5) and an adult sibling and her child were all home. The father was not at the home. The mother stated the older children were sleeping in their own beds and she was holding the infant while lying in her bed, because she had been crying. The

mother fell asleep holding her and woke to find the 8yo sibling and 5yo sibling both in the bed with her and the infant. The mother woke and did not see the infant lying next to her on the bed where she normally placed her. She found the infant lying face down underneath the 8yo sibling. The mother moved the sibling and picked the baby up, but she was not breathing. The mother called 911 and began CPR on the infant. First responders arrived and took the infant to the ER where she was pronounced dead. The mother told ECDSS she always allowed the children to sleep with her. The mother reported being a sound sleeper and thought on the evening of 9/22/09 the 8yo may have heard the baby crying and came into the room, picked her up and moved her. The mother stated that was the only explanation she could think as to why the baby was in a different place on the bed than where she had fallen asleep with her. The mother did have a bassinet for the infant, but did not use it because the baby cried a lot when placed in it.

ECDSS spoke with the adult sibling regarding the incident. She reported that the evening of 9/22/09, she saw the infant sleeping in the bassinet in the mother's room and the 8yo and 5yo were in her mother's bed. When she woke up to her mother screaming she learned the infant had died. The incident scared her, because she had a baby of her own at the time and was fearful this would happen to her. She reported practicing safe sleep.

The infant's father was spoken to by a secondary county at the request of ECDSS, as he was incarcerated out of the district. The father stated he was not at the home the night of the incident and he did not live there at the time. He denied knowing the mother slept in the bed with the infant and stated his understanding was the 8yo was sleepwalking that evening and wandered into the bedroom and laid on the infant. The father had no concerns about the mother's care for the children and denied she used alcohol or drugs.

ECDSS interviewed the 8yo and 5yo regarding the death of the infant. Neither sibling had any memory of how the infant died and could not provide any information regarding the fatality.

ECDSS requested all LE records and spoke with LE. ECDSS attempted to identify and locate first responders that had been at the home the day of the fatality, but were unable to find them due to the 10 years that had passed since the infant's death. ECDSS reviewed all police and medical records regarding the incident and spoke with the sibling's schools and pediatrician as part of their investigation. No concerns for the care of the children were noted.

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)? No
Comments: LE investigated the fatality in 2009, but ECDSS was not made aware of the fatality when it occurred, therefore it was not a joint investigation. ECDSS did contact LE when the SCR report was received regarding the death, and LE provided them with their records.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team? No
Comments: Erie County did not have an OCFS approved Child Fatality Review Team at the time of this fatality.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome

049685 - Deceased Child, Female, 4 Days	049687 - Father, Male, 37 Year(s)	Inadequate Guardianship	Unsubstantiated
049685 - Deceased Child, Female, 4 Days	049686 - Mother, Female, 34 Year(s)	DOA / Fatality	Substantiated
049685 - Deceased Child, Female, 4 Days	049686 - Mother, Female, 34 Year(s)	Inadequate Guardianship	Substantiated
049689 - Sibling, Male, 8 Year(s)	049686 - Mother, Female, 34 Year(s)	Inadequate Guardianship	Unsubstantiated
049689 - Sibling, Male, 8 Year(s)	049687 - Father, Male, 37 Year(s)	Inadequate Guardianship	Unsubstantiated
049690 - Sibling, Male, 5 Year(s)	049687 - Father, Male, 37 Year(s)	Inadequate Guardianship	Unsubstantiated

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?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
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?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☐	☐	☒	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:

Despite the efforts of ECDSS, many first responders could not be located or interviewed due to the time that had passed from the time of the death until the time the fatality was reported to the SCR . ECDSS contacted LE and reviewed their records

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:
The family was offered services at the Child Advocacy Center and declined. The mother denied that she or any of the children required any services in relation to the death of the child 10 years prior.

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 either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

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	☐	☒	☐	☐	☐	☐	☐
Other, specify: Child Advocacy Center							

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? N/A
Explain:
The fatality occurred 10 years prior in 2009, and no service needs were identified as a result of the fatality investigation.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A
Explain:
The fatality occurred in 2009, and no service needs were identified as a result of the fatality investigation.

History Prior to the Fatality

Child Fatality Report

Child Information

Did the child have a history of alleged child abuse/maltreatment?	No
Was there an open CPS case with this child at the time of death?	No
Was the child ever placed outside of the home prior to the death?	No
Were there any siblings ever placed outside of the home prior to this child's death?	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
- ☒ Was not noted in the case record to have any of the issues listed
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs

Infant was born:

- ☐ Drug exposed
- ☒ With neither of the issues listed noted in case record
- ☐ With fetal alcohol effects or syndrome

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)
05/05/2009	Sibling, Male, 7 Years	Mother, Female, 34 Years	Educational Neglect	Unsubstantiated	Yes

Report Summary:
An SCR report was received which alleged the 17yo surviving sibling (7yo at the time) had missed an extensive amount of school and it was negatively impacting her academic progress. The mother was alleged to have known about the absences and failed to intervene and get the child to school on a regular basis. The other siblings had unknown roles in the report.

Report Determination: Unfounded | **Date of Determination:** 06/15/2009

Basis for Determination:
After ECDSS became involved and spoke with the mother, the attendance of the sibling improved greatly and she was passing her classes. The mother acknowledged the child was missing school and remedied the issue. ECDSS educated the mother on the seriousness of educational neglect, and explained it could lead to Family Court involvement in the future if the children began missing school again. ECDSS offered Preventive Services to the family and the mother declined. Several referrals for service providers within the community were made and accepted by the mother.

OCFS Review Results:
ECDSS interviewed the mother and all the children, but did not contact the fathers, outside of sending Notice of Existence letters. The school was contacted and safety and risk assessments were completed timely.

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:
ECDSS did not document efforts to speak with the biological fathers of the children listed in the SCR report.

Legal Reference:
432.1 (o)
Action:
A Program Improvement Plan (PIP) has already been implemented to address the above cited concern. This PIP remains in effect as of the date of this fatality report and ECDSS continued to make progress in this area.

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

In October of 2002, two reports were made with allegations of LS and IG substantiated against the mother, regarding the 17yo (1yo at the time) sibling and 2 adult surviving siblings, who were children at the time of the report.

In November of 2002, two reports were made with allegations of LS and IG substantiated against the mother. Again, the children involved were the 1yo sibling and 2 adult siblings.

Two of the above listed reports involved one instance where the mother left the children alone in the home while she went out late at night. The other two reports were based on a single occurrence where the mother left the 1yo alone in the bathtub, while she slept for several hours.

There were 5 reports received between the time of the fatality and the time of the SCR reported fatality.
10/2010- An SCR report with an allegation of IG was indicated against the father for drug sales around children in another home.
11/2010- An SCR report with allegations regarding IG and PD/AM against the mother was unfounded.
3/2012- An SCR report as the result of a Court Ordered Investigation. The report had allegations of other against the mother and father of the 14yo SS and was unfounded.
10/2013- An SCR report with allegations of IG and LS against the mother was unfounded.
7/2016- An SCR report with an allegation of IG was indicated against the mother and adult siblings after a physical altercation occurred at the home in the presence of the surviving siblings.

Known CPS History Outside of NYS

There is no known history outside of New York State.

Preventive Services History

On 11/25/02, ECDSS filed a neglect petition against the mother after two instances where the 2 adult siblings and 1yo sibling were not properly supervised and were in danger of harm. On 12/5/02, the Family Court granted ECDSS supervision over the family. ECDSS referred the mother for Intensive Home Based Preventive Services and the services were provided by Parents Anonymous Program. There was no services recorded within Connections and was unclear what services were provided or when the case concluded.

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

Additional Local District Comments

We at the Erie County Department of Social Services (ECDSS) appreciate the opportunity given us to review the draft report in advance. We find that the facts, as written, describe the unfortunate events and the actions taken in response. We are pleased that OCFS found that the fatality investigation was conducted appropriately and that there are no required actions related to the fatality. Unfortunately, we must concur with the compliance issue noted by the reviewer with respect to a CPS investigation conducted within the three years preceding the fatality. Namely, with regard to the SCR report dated May 5, 2009, we acknowledge that, although ECDSS did send Notice of Existence Letters to the biological fathers of the children listed on the report, there is no documentation that efforts were made to speak with these fathers. We note, as does the reviewer, that ECDSS has already implemented a Program Improvement Plan to address this issue, and we have continued to make progress in this area.

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