Child Fatality Report

Report Identification Number: NY-17-048

Prepared by: New York City Regional Office

Issue Date: Nov 16, 2017

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: 1 month(s)

Jurisdiction: Kings
Gender: Male

Date of Death: 05/15/2017
Initial Date OCFS Notified: 05/15/2017

Presenting Information

The SCR registered a report alleging the parents found the one-month-old SC in his crib, cold and unresponsive. The report noted the mother called 911 at 10:04 A.M. to report the SC was not breathing. EMS responded to the case address and transported the SC to the hospital where he was pronounced dead at 10:52 A.M.

The report noted the SC was born premature and remained in the hospital after his birth due to difficulty breathing. However, at the time of his death, the SC had no pre-existing medical condition. The role of sibling was unknown.

Executive Summary

The SC was a month old when he died on 5/15/17. As of 11/15/17, the ME had not provided the cause and manner of death.

The parents and the two children resided with the MGM and a MU.

At the time of the SC's death, the mother was under COS and had an open case with ACS' Family Services Unit (FSU) involving the two children.

The family was known to ACS since 2012 concerning the SC's sibling. On 9/4/15, ACS filed an Article 10 Neglect Petition in Kings County Family Court (KCFC) for inadequate guardianship and lack of supervision of the sibling. The mother was listed as the respondent. The KCFC removed the sibling from the mother's care and released him to the MGM. A limited OOP was issued against the mother prohibiting her from interfering with the care and custody of the sibling. While under COS, the mother gave birth to the SC who was added to the existing petition on 4/10/17. The SC was released to the parents with COS. An OOP was issued against the mother with the condition she would not be left alone with the SC.

On 5/5/17, the mother consented to a neglect finding. The mother had completed parenting skills training and was engaged in clinical treatment. Therefore, Family Court released the sibling to the mother and the SC to the mother and his father with COS.

On 5/15/17, the SCR registered a report with allegations of DOA/Fatality and Inadequate Guardianship of the SC by the parents and the MU.

The investigation revealed that on 5/15/17, the parents went to a local bar at about 2:00 A.M. to celebrate Mother's Day and left the children in the care of the MGM. The parents returned sometime between 4:00 A.M and 5:00 A.M. as the MGM had to leave for work. The mother indicated she had three beers and the father had four. The MGM reported they did not show any signs of intoxication. The mother changed the SC, swaddled him and put him in the "baby rocker" to sleep. At about 9:30 A.M, the mother woke up and found the SC unresponsive. The family called 911 and began CPR as instructed by the 911 operator. The SC was transported to Brookdale Hospital where he was later pronounced dead.

At the time of the incident, the MGM was at work. The sibling was removed from the mother's care and placed with a MU who did not reside at the case address.

On 5/16/17, ACS held a Child Safety Conference (CSC) and returned to the KCFC as ACS determined court intervention was needed.

On 6/16/17, the sibling was released by the Family Court to the care of the MGM. The mother remained in the home with the condition that she would not be left alone with the child.

There were no concerns reported about the care the parents provided for the children. In addition, neither medical staff, NYPD or the ME found any signs of abuse on the SC's body. In addition, none of the first responders reported the parents were intoxicated.

As of 11/15/17, ACS has not made a determination.

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?** N/A
- **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?** The CPS report had not yet been determined at the time this Fatality report was issued.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
The investigation has not been determined.

Was the decision to close the case appropriate? N/A

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:
N/A

Required Actions Related to the Fatality

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

Child Fatality Report

Issue:	Failure to provide notice of report
Summary:	The appropriate Notice of Existence was not issued to the sibling's father.
Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(f)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 05/15/2017 **Time of Death:** 10:25 AM

Time of fatal incident, if different than time of death: 10:52 AM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: 10:04 AM
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
How long before incident was the child last seen by caretaker? 6 Hours
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was:

- ☐ Drug Impaired
- ☐ Alcohol Impaired
- ☐ Distracted
- ☐ Impaired by disability
- ☐ Absent
- ☒ Asleep
- ☐ Impaired by illness
- ☐ 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	Aunt/Uncle	Alleged Perpetrator	Male	28 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	1 Month(s)

Deceased Child's Household	Father	Alleged Perpetrator	Male	23 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	26 Year(s)
Deceased Child's Household	Sibling	No Role	Male	5 Year(s)

LDSS Response

ACS' investigation revealed that on 5/15/17, to celebrate Mother's Day, the parents went to a bar/restaurant located on the first floor of the building where they resided.

The parents left the home around 2:00 A.M., and at 4:00 A.M. the MGM sent a text message to ask them to return because she had to leave for work at about 5:00 A.M. The mother said she went up first and attended to the children while the father remained downstairs.

The mother allowed the sibling to continue to sleep in the MGM's bedroom. The SC was asleep in his rocker, so she took him into their room. The mother said the SC was crying and a bit fussy. The SC had been fed and burped by the MGM at about 3:30 A.M. The mother then changed the SC to make him comfortable. The mother said the SC seemed congested, so she rubbed Vick's on his face and chest. She then gave the SC his pacifier. Once the SC fell asleep on the mother's chest, she placed him in the rocker and then placed the rocker in the crib. The mother said the SC liked sleeping in the rocker instead of in the crib.

The mother said that after she attended to the children, she returned to the bar for the father. The time they returned was not clear. The mother indicated she fell asleep at about 6:00 A.M. and woke up at about 9:30 A.M. The mother said she checked the SC and found him unresponsive. The mother observed the SC's lips were purple, he was not breathing and he felt very cold. The mother said she began to scream and the father attempted to call 911. Since the father was in a panic, the MU took the father's cell phone and called 911. The mother began to administer CPR as instructed by the operator.

EMS indicated the SC was unresponsive and pulse less. EMS found no indication of abuse on the SC's body. ACS interviewed first responders and none reported concerns about the parents being intoxicated at the time of the incident.

The MGM was at work when the SC was found unresponsive. ACS removed the sibling from the home temporarily as it was unclear whether the parents were responsible for the SC's death. The MGM also indicated the parents were fine when they returned to the home.

On 6/15/17, ACS returned to the KCFC and the mother was to continue with the COS. The sibling remained with the MU and released to the MGM on 6/16/17. Family Court ordered the mother to submit to random drug screening, re-engage in clinical treatment and counseling for her and the sibling. Preventive services were recommended and a referral was made by ACS. Shortly after fatality investigation, the mother and the SC's father separated.

ACS returned to the KCFC and the sibling was again released to the MGM on 6/16/17. ACS has not made contact with the sibling's father.

ACS maintained contact with the ME who indicated there was no foul play, internal or external injuries. However, no preliminary cause or manner of death was provided.

ACS made collateral contacts and learned there were no concerns about the sibling's academic or medical care of the children.

As of 11/15/17, ACS had not made a determination and case notes indicated last contact with the ME occurred in August.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Unknown
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: The investigation adhered to previously approved protocols for joint investigations.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: There is no OCFS approved Child Fatality Review Team in the NYC Region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
039941 - Deceased Child, Male, 1 Mons	039944 - Aunt/Uncle, Male, 28 Year(s)	DOA / Fatality	Pending
039941 - Deceased Child, Male, 1 Mons	039944 - Aunt/Uncle, Male, 28 Year(s)	Inadequate Guardianship	Pending
039941 - Deceased Child, Male, 1 Mons	039942 - Mother, Female, 26 Year(s)	Inadequate Guardianship	Pending
039941 - Deceased Child, Male, 1 Mons	039942 - Mother, Female, 26 Year(s)	DOA / Fatality	Pending
039941 - Deceased Child, Male, 1 Mons	039943 - Father, Male, 23 Year(s)	DOA / Fatality	Pending
039941 - Deceased Child, Male, 1 Mons	039943 - Father, Male, 23 Year(s)	Inadequate Guardianship	Pending

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

Additional information:
N/A

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 safety 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:
In practice ACS addressed the risk factors appropriately, but the RAP was not completed properly. ACS listed the SC's father as the secondary caretaker as opposed to the MGM.

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?	☒	☐	☐	☐
If Yes, court ordered?	☐	☒	☐	☐

Explain as necessary:
At the time of the fatality, the sibling was already under COS. After the fatality, the SC was informally placed with a MU who resided out of the home.

Legal Activity Related to the Fatality

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

Have any Orders of Protection been issued? No

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Needed but 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	☐	☐	☐	☐	☐	☒	☐
Additional information, if necessary: N/A							

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? Yes
Explain:
The sibling was removed from the home temporarily. Services were offered and accepted. PPRS will coordinate.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
Services were offered and accepted. The family will receive PPRS to coordinate services. PPRS will coordinate.

History Prior to the Fatality

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?	Yes
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)	Status/Outcome	Compliance Issue(s)
07/09/2015	Sibling, Male, 3 Years	Mother, Female, 25 Years	Lack of Supervision	Indicated	Yes
	Sibling, Male, 3 Years	Grandparent, Female, 46 Years	Inadequate Guardianship	Unfounded	
	Sibling, Male, 3 Years	Other - MGU, Male, 61 Years	Lack of Supervision	Unfounded	
	Sibling, Male, 3 Years	Mother, Female, 25 Years	Inadequate Guardianship	Indicated	
	Sibling, Male, 3 Years	Other - MGU, Male, 61 Years	Inadequate Guardianship	Unfounded	

Report Summary:
On 7/9/15, the SCR registered a report alleging the mother and a MU had a history of leaving the then 3-year-old sibling unsupervised in the home. The report alleged the MGM and the mother were aware the uncle left the sibling unsupervised yet did not address the issue. In addition, the mother admitted leaving the sibling alone without properly planning for his care.

Determination: Indicated **Date of Determination:** 09/07/2015

Basis for Determination:
ACS substantiated the allegations of Inadequate Guardianship and Lack of Supervision of the sibling by the mother as she admitted to leaving the SC unattended. ACS also cited the mother was not taking her prescribed medication on the weekends which made her behavior “irrational.”

The allegation of Inadequate Guardianship and Lack of Supervision were unsubstantiated against the MGU because ACS determined he was not a person legally responsible.

ACS unsubstantiated the report against the MGM because she was not the sibling's "legal guardian" and worked full time.

OCFS Review Results:
NYCRO found that ACS unsubstantiated the allegation against the MGM noting she was not a "legal, but she was listed as a secondary caretaker in the Risk Assessment Profile. The mother resided with the sibling in the MGM’s home.

On 9/4/15, ACS filed an Article 10 Neglect Petition listing the mother as the respondent. The MGM admitted she was aware the mother was leaving the sibling unsupervised and took no action to address the matter. The sibling was removed from the mother’s care and released to the MGM. ACS requested the mother be excluded from the the home, but this petition was not granted.

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

Issue:
Failure to provide notice of report

Summary:
The Notice of Existence was not issued for the father.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)

Action:
ACS must meet with the staff involved in this investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

Issue:
Failure to Provide Notice of Indication

Summary:
The Notices of Indication were not issued for the subjects, father or other adults in the home.

Legal Reference:
18 NYCRR 432.2(f)(3)(xi)

Action:
ACS must meet with the staff involved in this investigation and inform NYCRO of the date of the meeting, who attended, and what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.

[redacted]

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

The mother was registered as the subject of three unfounded reports dated 4/16/12, 11/29/12 and 2/28/13. The allegation of these reports was Inadequate Guardianship.

Known CPS History Outside of NYS

There is no known CPS history outside NYS.

Preventive Services History

The family was involved with the Brooklyn Bureau for preventive services from 5/8/12 through 8/18/14. The family received counseling and homeaking services. The services ended once the family was stable.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation?

☒ Family Court ☐ Criminal Court ☒ Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
09/04/2015	Adjudicated Neglected	Direct Custody Transferred toContinued with Relative (Article 10)
Respondent:	039942 Mother Female 26 Year(s)	
Comments:	The KCFC ordered services and COS. The mother was allowed to remain in the home of the MGM with a limited OOP issued on 9/4/15. The petition to exclude the mother from the home was not granted.	

Have any Orders of Protection been issued? Yes	
From: 09/04/2015	**To:** Unknown

Explain:
An OOP was issued against the mother and has been ongoing as the mother continues to reside with the MGM who has the custody of the sibling.

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