

Report Identification Number: NY-20-021

Prepared by: New York City Regional Office

**Issue Date: Aug 12, 2020** 

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 <u>only</u> 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
DrDoctor	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	ACS-Administration for Children's	NYPD-New York City Police
Service	Services	Department
PPRS-Purchased Preventive	TANF-Temporary Assistance to Needy	FC-Foster Care
Rehabilitative Services	Families	
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	ASTO-Allowing Sex Abuse to Occur	



### **Case Information**

**Report Type:** Child Still Born **Jurisdiction:** New York **Date of Death:** Unknown

Age: Unknown Gender: Female Initial Date OCFS Notified: 02/22/2020

#### **Presenting Information**

The report alleged in 2017, the BM gave birth to a female infant. At the time of the infant's birth, the BM tested positive for an unknown drug. The infant subsequently died after being born due to the BM's drug use.

The BM had a history of abusing crack cocaine, cocaine, K2, and marijuana during the pregnancy. She was diagnosed with a clinical health condition and was not diligent about her medications. As a result, she had erratic behavior while being the sole caretaker of a male child, whom she gave birth to in February of 2020.

#### **Executive Summary**

According to ACS case documentation, at 1:00 AM on 11/26/16, the female SC was delivered as stillborn after 24 weeks of gestation. The SC did not have any spontaneous respiration, audible breath sounds, cardiac activity, and pulse. At 2:00 AM, the medical staff pronounced the SC dead. An autopsy was not performed and there was no LE or ACS involvement regarding the SC's death.

In February of 2020, the BM gave birth to the surviving sibling (SS). The SS was born with a positive toxicology for marijuana at birth. Following the SS' birth, the BM and the SS were placed in a mother/child program to support the BM's sobriety, clinical health concerns and parenting. The BF was not involved with the SS and his whereabouts were unknown. The BF had an extensive CPS history with his older children and their respective mothers due to concerns of DV and drug abuse. The BF's older children and their mothers were not known to the BM and her children.

On 2/22/2020, ACS received the report and initiated the CPS investigation in a timely manner. ACS obtained medical documentation that reflected the SC was stillborn and was pronounced dead in the hospital shortly after the BM gave birth to her. ACS also obtained information from the hospital staff, service provider, and the BM. The BM admitted to using marijuana during her pregnancy with the SS. The hospital staff and the service provider reported concerns about the BM's clinical health condition and her parenting. Consequently, ACS filed an Article 10 Neglect Petition against both parents in Family Court to protect the SS. The court released the SS to the BM with COS. Due to ongoing concerns about the care the BM gave to the SS, ACS conducted an emergency removal of the SS. The court granted a remand of the SS and he was placed in non-kinship foster care. The court also granted the BM supervised visits. On 3/12/20, a 1028 hearing was held, and the court released the SS to the BM's care.

The BM continued to reside in a residential drug treatment facility. ACS maintained regular phone contacts with the service provider and the BM. The service provider closely supervised the family and reported the BM and the SS were doing well. The BM tested negative for all illicit substances and complied with her clinical health services. She received parenting skills training. The BM regularly sent the SS' pictures to ACS for assessments and there were no concerns for the child.

On 4/22/2020, ACS substantiated the allegation IG of the SS by the BM. The SS was born with a positive toxicology for marijuana and the BM admitted to using marijuana during her pregnancy. On more than one occasion, the BM co-slept with the SS despite repeatedly being counseled on the dangers of co-sleeping. ACS also based its decision on the BM's admission that she "could not do it any longer" when she handed the SS over to a facility staff to care for the SS. Additionally, the BM took the SS out in cold weather without the appropriate warm clothing.



ACS unsubstantiated the allegations DOA/Fatality, IG, and PD/AM of the SC against the BM. ACS obtained medical documentation that revealed the SC was delivered as a stillborn in 2016.

# 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 Yes or regulatory requirements?

Was there sufficient documentation of supervisory consultation?

No

## **Explain:**

Although, there was documentation of supervisory consultation during the investigation, there were no thorough supervisory reviews regarding documentation to support the findings of abuse in the investigation conclusion narrative.

#### **Required Actions Related to the Fatality**

Are there Require	d Actions related to the compliance issue(s)?  \( \subseteq \text{Yes}  \text{INo} \)			
Issue:	Timely/Adequate 30-Day Safety Assessment			
Summary:	ACS did not complete the 30-Day Safety Assessment document.			
<b>Legal Reference:</b>	CPS Program Manual, Chapter 6, K-2			
Action:	ACS must submit a PIP within 45 days that identifies the action the agency will take or took to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.			
Issue:	Determination of Nature, Extent and Cause of Conditions (Report)			
Summary:	ACS did not document any information in the investigation conclusion narrative to support the findings of abuse.			

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Legal Reference:	18 NYCRR 432.2(b)(3)(ii)(d)			
Action:	ACS must submit a PIP within 45 days that identifies the action the agency will take or took to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.			
Issue:	Pre-Determination/Supervisor Review			
Summary:	There was no thorough supervisory involvement/review regarding documentation to support the findings of abuse in the investigation conclusion narrative.			
Legal Reference:	18 NYCRR 432.2(b)(3)(v)			
Action:	ACS must submit a PIP within 45 days that identifies the action the agency will take or took to address the citations identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who attended and what was discussed.			

# **Fatality-Related Information and Investigative Activities**

## **Household Composition at time of Fatality**

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	
Deceased Child's Household	Mother	Alleged Perpetrator	Female	24 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	1 Day(s)
Other Household 1	Father	No Role	Male	36 Year(s)
Other Household 2	Father	No Role	Male	30 Year(s)

# **LDSS Response**

On 2/22/2020, ACS visited the hospital and assessed the safety of the SS. The SS appeared medically stable and did not show any signs of drug withdrawals. The BM admitted to drug misuse during pregnancy for the SS. She reported having unstable housing and did not have provisions for the SS. She was aware of safe sleep practice. She denied the whereabouts of the two BFs. She stated the SS' BF was not involved with the newborn.

The hospital staff reported the BM received prenatal care. The BM and the SS would be discharged on 2/25/20, to a mother and child drug treatment program.

On 2/23/2020, the BM denied cocaine use. She reported having a clinical health diagnosis but was not receiving counseling or medication.

On 2/25/2020, the BM was admitted to the mother and child inpatient substance abuse residential treatment program

On 2/25/2020, the BF's spouse denied she knew the BM. She also denied the BF resided with her as she had an active OP against the BF.

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On 2/25/2020, ACS obtained the SC's death record. The record reflected at about 2:00 AM on 11/26/16, the ER physician pronounced the SC dead. The SC did not have any spontaneous respiration, no audible breathing sounds or cardiac activity, no pulse and was determined to be a stillborn delivery.

On 2/26/2020, ACS held a child safety conference (CSC). The CSC agreed to seek court intervention to protect the SS. The CSC also recommended mental health evaluation, and random drug screening for the BM; and EI for the SS.

On 2/27/20, ACS filed an Article 10 Neglect Petition against both parents in Family Court. The SS was released to the BM with COS. The BM would remain at the mother and child program and adhere to the program's recommendations.

On 2/28/2020, ACS visited the BM at her residence. ACS did not document any safety concerns for the home. Following the visit, ACS received the SS' hospital discharge records. He passed his hearing screening and was discharged with no acute distress.

On 3/2/2020, the service provider stated that on more than one occasion, the BM was found co-sleeping with the SS. She brought the SS outside without the appropriate warm clothing. The BM handed the SS to a facility staff and stated that she "could not do it any longer." Additionally, she was not taking her prescribed medication.

On 3/2/20, ACS conducted an emergency removal of the SS and on 3/3/2020, the Family Court issued a remand for the SS.

On 3/12/20, a 1028 hearing was held in Family Court. The court released the SS to the BM with ACS supervision.

On 3/19/2020, the BM's CP reported the service provider would continue to work with the BM to improve on her parenting skills and address any of negative behavior.

On 3/26/2020, ACS referred the SS for EI services.

Between 4/2/2020 and 4/12/2020, the service provider reported the BM continued to co-sleep with the SS despite repeatedly being counseled against it. The BM was also involved in several verbal altercation with other residents.

On 4/13/2020, the BM denied all the service provider's concerns. ACS counseled the BM about dangers of co-sleeping. ACS then delivered a stroller to the BM for the SS.

On 4/17/2020, the BM denied any new concerns of drug use, and non-compliance with clinical health services. She said she tested negative for drug use and had been taking her prescribed medication. She denied having any contact with the BF.

On the same day, the service provider reported the BM was relocated to another floor at the facility as a pandemic precaution where she and the SS were being monitored more closely by the medical staff. Both the BM and SS' temperature were being monitored regularly as well as their overall health.

On 4/22/2020, ACS substantiated the allegation of IG of the SS by the BM. ACS unsubstantiated the allegations DOA/Fatality, IG, and PD/AM of the stillborn SC against the BM.

#### Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? No

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**Comments:** The report did not meet the criteria for use of MDT.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No

**Comments:** There is no OCFS approved Child Fatality Review Team in New York City Region.

## **SCR Fatality Report Summary**

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
053461 - Deceased Child, Female,	053464 - Mother, Female, 24 Year(s)	DOA / Fatality	Unsubstantiated
053461 - Deceased Child, Female,	053464 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Unsubstantiated
053461 - Deceased Child, Female,	053464 - Mother, Female, 24 Year(s)	Parents Drug / Alcohol Misuse	Unsubstantiated
053465 - Sibling, Male, 1 Day(s)	053464 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Substantiated

# **CPS Fatality Casework/Investigative Activities**

	Yes	No	N/A	Unable to Determine
All children observed?	$\boxtimes$			
When appropriate, children were interviewed?			$\boxtimes$	
Alleged subject(s) interviewed face-to-face?	$\boxtimes$			
All 'other persons named' interviewed face-to-face?		$\boxtimes$		
Contact with source?	$\boxtimes$			
All appropriate Collaterals contacted?	$\boxtimes$			
Was a death-scene investigation performed?			$\boxtimes$	
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?			$\boxtimes$	
Did the investigation adhere to established protocols for a joint investigation?				
Was there timely entry of progress notes and other required documentation?	$\boxtimes$			

## **Fatality Safety Assessment Activities**

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	$\boxtimes$			



Was there an adequate assessment of impending or immediate danger to s household named in the report:	urviving	siblings/c	ther chil	dren in the
Within 24 hours?	$\boxtimes$			
At 7 days?	$\boxtimes$			
At 30 days?		$\square$		
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	$\boxtimes$			
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	N 2			
harm, were the safety interventions, including parent/caretaker actions adequate?				
Explain: ACS did not complete the 30-Day Safety Assessment.				
Fatality Risk Assessment / Risk Assessment I	Profile			
	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	$\boxtimes$			
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	$\boxtimes$			
Was there an adequate assessment of the family's need for services?	$\boxtimes$			
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?	$\boxtimes$			
Were appropriate/needed services offered in this case	$\boxtimes$			
Placement Activities in Response to the Fatality In	ivestigatio	<u>n</u>		
	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?	$\boxtimes$			

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## Explain as necessary:

On 2/27/20, ACS filed an Article 10 Neglect Petition against both parents in Family Court. The SS was released to the BM with COS. On 3/2/20, ACS conducted an emergency removal of the SS. On 3/3/20, an Order To Show Cause was filed and the court granted a remand of the SS. He was placed in non-kinship foster care. The court also granted the BM supervised visits. On 3/12/20, Family Court released the SS to the BM's care.

	Legal Activity Related to the Fatality							
<b>Was there leg</b> . ⊠Family Cou	al activity as a result of the fatality investigation?  The contract of the fatality investigation?  The contract of the fatality investigation?	Order of Protection						
Family Cour	t Petition Type: FCA Article 10 - CPS							
Date Filed:	Fact Finding Description:	Disposition Description:						
02/27/2020	There was not a fact finding  There was not a disposition							
Respondent:	053464 Mother Female 24 Year(s)							
Comments:	On 2/27/20, ACS filed an Article 10 Neglect Petition against both parents in Family Court. The SS was released to the BM with COS. On 3/2/20, ACS conducted an emergency removal of the SS due to safety concerns at the BM's residence. A remand was granted on 3/3/20. On 3/12/20, the court released the SS to the BM's care. The SS was in foster care from 3/2/2020 until 3/12/2020.							

## 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							
<b>Economic support</b>							
Funeral arrangements							
Housing assistance							
Mental health services							
Foster care							
Health care							
Legal services							
Family planning							
<b>Homemaking Services</b>							
Parenting Skills	$\boxtimes$						
<b>Domestic Violence Services</b>						$\boxtimes$	
Early Intervention							
Alcohol/Substance abuse	$\boxtimes$						

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Child Care			$\boxtimes$	
Intensive case management				
Family or others as safety resources			$\boxtimes$	
Other			$\boxtimes$	

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 SM delivered a stillborn in 2016 and there was no ACS involvement.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? N/A

## **Explain:**

The fatality was a stillborn in 2016.

# **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)
10/19/2019	Other Child - Unknown, Female, 2 Years		Clothing / Shelter	Unsubstantiated	
	Other Child - Unknown, Female, 2 Years	Mother's Partner, Male, 36 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - Unknown, Female, 2 Years		Misuse	Unsubstantiated	
	Other Child - Unknown, Female, 2 Years	Mother's Partner, Male, 36 Years	Sexual Abuse	Unsubstantiated	
	Other Child - Unknown, Female, 2 Years	1	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Other Child - Unknown, Female, 2 Years	Mother, Female, 22 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - Unknown, Female, 2 Years		Parents Drug / Alcohol Misuse	Unsubstantiated	
	Other Child - Unknown, Female, 2 Years	Mother, Female, 22 Years	Sexual Abuse	Unsubstantiated	

### Report Summary:

The parent substitute (PS) sexually abused the unknown 2-year-old child on an ongoing basis and the BM was aware but, failed to intervene and ensure the abuse stopped. The PS touched the unknown child's vagina in a sexual manner and forced the child to perform oral sex on him on an ongoing basis. The PS beat the BM in the presence of the child. The child did not sustain any injuries. The BM and PS smoked K2 and took molly to the point of impairment while being the sole caretakers of the child. They sold drugs out of the home while the child was present. The child missed meals and as a result was underweight and begged for food.

Report Determination: Unfounded Date of Determination: 12/18/2019



#### **Basis for Determination:**

Throughout the investigation, ACS did not find credible evidence to determine the BM had a child in her care. The service providers confirmed the BM did not have a child. The PATH confirmed the BM entered the shelter system without a child. The BM spent a few days at a drug treatment program and the staff confirmed the BM did not come into the program with a child. Despite diligent efforts made, ACS was unable to locate the PS to interview him about the allegations of the report.

#### **OCFS Review Results:**

ACS' decision to unsubstantiate the allegations of the report was appropriate.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
09/28/2019	Other Child - Unknown, Female, 2 Years	Mother's Partner, Male, 35 Years	Inadequate Guardianship	Unsubstantiated	No
	Other Child - Unknown, Female, 2 Years	Mother's Partner, Male, 35 Years	Sexual Abuse	Unsubstantiated	
	Other Child - Unknown, Female, 2 Years	Mother, Female, 22 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - Unknown, Female, 2 Years	Mother, Female, 22 Years	Sexual Abuse	Unsubstantiated	
	Other Child - Unknown, Female, 2 Years	Mother, Female, 22 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Other Child - Unknown, Female, 2 Years	Mother's Partner, Male, 35 Years	Allowing Sex Abuse to Occur		
	Other Child - Unknown, Female, 2 Years	Mother, Female, 22 Years	Allowing Sex Abuse to Occur	Unsubstantiated	

#### Report Summary:

There were concerns of sexual abuse of the 2-year-old child by the parent substitute (PS) and the BM. Also, the report alleged drug use to the point of impairment and prostitution by the BM. In addition, the PS sold drugs out of the home in the presence of the child and kept guns in the home that were accessible to the child. The PS was physically aggressive and had physically assaulted the BM in the presence of the child and had on at least one occasion, punched the child in the face.

**Report Determination:** Unfounded **Date of Determination:** 11/21/2019

## **Basis for Determination:**

Throughout the investigation, ACS did not find credible evidence to determine the BM had a child in her care. ACS obtained information from several collateral contacts and verified the BM did not have a child. The PATH confirmed the BM entered the shelter system without a child. The BM also spent a few days at a drug treatment program and the staff confirmed the BM did not come into the program with a child.

#### **OCFS Review Results:**

Based on the case documentation, the determination was appropriate.

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

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

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

**Known CPS History Outside of NYS** 



There was no CPS history from another 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