Office of Children and Family Services

Child Fatality Report

Report Identification Number: RO-21-026

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

Issue Date: Mar 29, 2022

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	ASTO-Allowing Sex Abuse to Occur	

Case Information

Report Type: Child Deceased
Age: 11 year(s)
Jurisdiction: Monroe
Gender: Female
Date of Death: 10/31/2021
Initial Date OCFS Notified: 11/01/2021

Presenting Information

Monroe County Department of Human Services (MCDHS) received an SCR report alleging that the 11-year-old subject child had a seizure at approximately 10:52PM on 10/31/21 and passed away as a result. The mother called 911 at 11:07PM and emergency medical services responded to the home and pronounced the child dead at 11:15PM. It was alleged the subject child was otherwise healthy and the mother had no explanation for her death.

Executive Summary

This report concerns the death of the 11-year-old female subject child that occurred on 10/31/21. At the time of the subject child's death, she resided at home with her mother and siblings, ages 17 and 18 years old. An autopsy was completed; however, the final report had not yet been issued at the time of this writing, and the cause and manner of death remained pending.

The investigation revealed the subject child had a history of seizures and other medical complications. It was learned the child had several seizures during the day on 10/31/21, which was not uncommon. During the evening, the mother left the 18-year-old sibling at the home to supervise the subject child while she went to the store with a friend sometime after 9:00PM. The sibling completed chores around the house and made dinner while the mother was gone, checking on the subject child occasionally. At approximately 10:45PM, the sibling checked on the subject child and found she was cold and unresponsive. The sibling called her mother and then called 911 at 11:07PM. First responders arrived and found the subject child to be deceased as rigor mortis had set in. The child was pronounced deceased at the home at 11:15PM.

MCDHS provided the mother with information for grief and mental health counseling. Community-based referrals were provided for the siblings, but they reported they were receiving support within the community already. MCDHS learned the 17-year-old sibling was pregnant and provided community-based referrals for expectant mothers and information on safe sleep. MCDHS spoke with family members and collateral sources including law enforcement, medical staff, and the medical examiner. MCDHS did not find credible evidence to substantiate the allegations of DOA/Fatality and IG against the mother regarding the subject child. MCDHS determined the death was not the result of abuse or neglect, but rather the child's medical condition. There were no reported signs of trauma and the subject child had been receiving proper medications. The sibling received training on how to appropriately care for the subject child and the care she provided at the time of the subject child's death was suitable. No further service needs were identified as the sibling turned 18 during the investigation and there were no minor siblings or other children residing in the home. MCDHS conducted a thorough investigation in accordance with multidisciplinary standards and recorded casework activity and required assessments timely and accurately.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**

- **Approved Initial Safety Assessment?** Yes
- **Safety assessment due at the time of determination?** Yes

- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:
The case was appropriately determined and closed once case objectives were met.

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:
Casework activity was commensurate with case circumstance and there was detail of supervisory consultation.

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: 10/31/2021 **Time of Death:** 11:15 PM

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

County where fatality incident occurred: Monroe
Was 911 or local emergency number called? Yes
Time of Call: 11:07 PM
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: having a seizure

Did child have supervision at time of incident leading to death? Yes
At time of incident was supervisor impaired? Not impaired.
At time of incident supervisor was:
☐ Distracted ☐ Absent
☐ Asleep ☒ Other: **N/A, the sibling was present and not impaired**

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	11 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	36 Year(s)
Deceased Child's Household	Sibling	No Role	Female	17 Year(s)
Deceased Child's Household	Sibling	No Role	Female	18 Year(s)
Other Household 1	Other Adult - Father of Sibling	No Role	Male	37 Year(s)
Other Household 2	Father	No Role	Male	42 Year(s)

LDSS Response

On 11/1/21, MCDHS received the SCR fatality report regarding the subject child. Upon receipt of the fatality report, MCDHS initiated their investigation within 24 hours and coordinated efforts with their MDT.

MCDHS interviewed the mother and siblings immediately upon receipt of the report on 11/1/21. It was learned the subject child had several seizures throughout the day on 10/31/21. The mother reported one of the seizures was significant, so she laid the subject child down on the couch as the child got tired after having a big seizure. The mother went to the store with a friend in the evening and left the eldest sibling home with the subject child. The sibling supervised the subject child while the mother was gone. The subject child stayed on the couch while the oldest sibling made dinner. At 10:12PM, the mother called and asked the sibling to check on the subject child, which she did. Upon placing her hand on the subject child's cheek, she noted the child was warm and responsive. The subject child responded by grunting as she was nonverbal, and it was reported that was her only form of verbal communication. The sibling placed a blanket over the subject child and ate dinner in a room away from the subject child. At approximately 10:45PM, the sibling checked on the subject child again and found her to be cold and unresponsive. She called the mother and then 911 and first responders arrived approximately 15 minutes later. The subject child was not transported to the hospital as it was determined she was deceased and could not be revived. The child's time of death was 11:15PM.

Medical records revealed the child suffered from a neurological disorder and multiple medical conditions since birth. The subject child was seen at her neurologist's office regularly but missed an appointment in June. The provider reported there was not a pattern of missed appointments as the mother was consistent in getting her to appointments. The neurologist reported that Sudden Unexplained Death (SUDEP) was not uncommon in children with epilepsy. The records revealed the mother called each time she had concerns and the child was seen approximately once a year in their office. The neurologist reported the mother acted appropriate during each appointment and there were no concerns for medical compliance or safety. It was noted in the records that the subject child had more seizures during the day when she was not feeling well.

The record did not reflect whether the mother called the provider on the day of her death due to the number and severity of her seizures. Medical records regarding the 17-year-old sibling were received and there were no concerns documented.

The 17-year-old sibling was assessed to be safe in the care of the mother. No safety concerns were revealed for the surviving sibling as the unsafe situation was isolated to the circumstances of the subject child's vulnerability. The sibling reported she was trained on how to care for the subject child and administer her medication. During the investigation it was learned the sibling was pregnant. MCDHS provided safe sleep education and community-based referrals for expectant mothers to the sibling. The sibling turned 18 during the investigation and there were no other minor siblings or children residing in the home at the time the investigation was closed.

Law enforcement advised MCDHS of their interviews with the family. Law enforcement corroborated the mother and sibling's account of the incident. Law enforcement determined there was no criminality or foul play suspected in the death and closed their investigation. A phone conversation with the medical examiner revealed the preliminary cause of death to be seizure disorder and manner of death to be natural. The appropriate fatality-related services were offered, and the case was closed upon sufficiently gathering information to determine the investigation.

Official Manner and Cause of Death

Official Manner: Natural
Primary Cause of Death: From a medical cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? Yes
Comments: MCDHS adhered to previously approved protocols for joint investigations by notifying the DA's office of the death and coordinating efforts with law enforcement.

Was the fatality referred to an OCFS approved Child Fatality Review Team? Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
059855 - Deceased Child, Female, 11 Yrs	059864 - Mother, Female, 36 Year(s)	DOA / Fatality	Unsubstantiated
059855 - Deceased Child, Female, 11 Yrs	059864 - Mother, Female, 36 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?	☒	☐	☐	☐
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:
Relevant collateral sources were spoken to.

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 sibling was seventeen at the time of the subject child's death and turned eighteen over the course of the investigation. She was deemed safe in the care of the mother and referrals for community-based services were offered.

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?	☐	☒	☐	☐

Explain as necessary:
There was no removal of the sibling.

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: community-based services							
Additional information, if necessary: MCDHS provided the mother and sibling with referrals for community-based services related to bereavement and mental health counseling. MCDHS provided the sibling with safe sleep education upon learning of her pregnancy.							

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:
MCDHS provided referrals for community-based resources related to mental health and bereavement counseling to the sibling. The sibling was already engaged in services within the community and declined additional service needs.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
MCDHS provided referrals for community-based resources related to mental health and bereavement counseling to the mother. The mother declined services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? 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? Yes

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)
02/22/2021	Deceased Child, Female, 11 Years	Mother, Female, 35 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Deceased Child, Female, 11 Years	Mother, Female, 35 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Deceased Child, Female, 11 Years	Mother, Female, 35 Years	Lack of Supervision	Unsubstantiated	

Report Summary:
MCDHS received a report from the SCR alleging the subject child was non-verbal, had a seizure disorder, and required a higher level of care and supervision to meet her basic needs. The mother failed to properly supervise the subject child for an extended period of time and the child sustained a laceration on her wrist and multiple lacerations on her legs.

Report Determination: Unfounded | **Date of Determination:** 05/21/2021

Basis for Determination:
MCDHS determined there was no credible evidence to substantiate the allegations. The subject child was observed to have appropriate supervision during each home visit. The family reported the scratches on the subject child came from a new puppy. The puppy was observed by MCDHS to be rambunctious and jumping on all family members. A visiting nurse who was in the home regularly confirmed the subject child was always appropriately supervised. The mother reported the mark on the child's wrist occurred when she tried to get food out of the toaster oven. The mother reported the child was being supervised at the time.

OCFS Review Results:
MCDHS assessed safety within the first seven days, but did not complete the Safety Assessment tool in CONNECTIONS until 9 days after receipt of the report. MCDHS contacted relevant collateral sources and obtained medical records. Concerns arose during the case related to the child's attendance at school during remote school days as well as injuries sustained during a seizure, but the new concerns were not addressed with the mother.

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

Issue:
Pre-Determination/Nature, Extent and Cause of Any Condition

Summary:
New information, concerns, and evidence became apparent during the investigation regarding the allegation of EdN for the subject child but allegations were not added nor were they addressed with the mother. The subject child presented to school with black eye and other injuries alleged to have occurred during a seizure, but the injuries and concerns were not addressed with the mother.

Legal Reference:
18 NYCRR 432.2(b)(3)(iii)(c)

Action:
MCDHS will make an adequate assessment of the nature, extent and cause of any condition which may constitute abuse or maltreatment, whether contained in the original SCR report or discovered during the open investigation.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
11/02/2020	Deceased Child, Female, 10 Years	Mother, Female, 35 Years	Burns / Scalding	Unsubstantiated	Yes
	Deceased Child, Female, 10 Years	Mother, Female, 35 Years	Lack of Supervision	Unsubstantiated	
	Deceased Child, Female, 10 Years	Mother, Female, 35 Years	Lack of Medical Care	Substantiated	

Report Summary:
MCDHS received a report from the SCR alleging that the subject child was non-verbal and required a higher level of care to meet her basic needs. The mother was aware and failed to provide adequate supervision for the then 10-year-old subject child. As a result, the subject child grabbed boiling water off the stove and spilled it on her inner thighs.

Report Determination: Indicated | **Date of Determination:** 02/11/2021

Basis for Determination:
MCDHS determined there was credible evidence to support substantiating the allegation of LMC against the mother

regarding the subject child. The mother failed to provide seizure medication to the school for the child's ongoing seizure disorder. MCDHS exhausted efforts to obtain appropriate medical records and learned the mother did not get medical care for the child after she sustained burns to her thighs and she was not being seen as recommended for her seizure disorder. MCDHS determined there was no credible evidence to substantiate LS and B/S as the child was being supervised at the time she pulled the boiling water off the stove.

OCFS Review Results:
MCDHS completed casework within the required timeframes. MCDHS had a legal consult due to the concerns for the subject child, but it was determined during the consultation that there was no sufficient evidence to file a petition. MCDHS exhausted efforts to obtain appropriate medical documents and speak with relevant collateral sources. The safety assessments did not accurately reflect the ongoing concerns for the mother's failure to meet the subject child's needs for medical care, though the allegations were substantiated and the concerns rose to the level that a legal consultation was deemed necessary.

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

Issue:
Timely/Adequate Seven Day Assessment

Summary:
MCDHS substantiated allegation of LMC and made a safety plan for the child related to her medical needs. MCDHS sought legal consultation as the concerns rose to a level that filing a petition was considered, but the safety assessments at the seven day and time of determination reflected there were "no safety factors present."

Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)

Action:
MCDHS will document and approve all assessments and accurately reflect the safety factors that are present, along with any safety plan that has been devised.

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

There was indicated history dating back to 2015 regarding the mother's lack of supervision and failure to meet the needs of the subject child. In 2015, the mother failed to provide the subject child with appropriate supervision given her significant delays and medical needs. The mother left the subject child in the care of her teenaged siblings who were not able to meet the subject child's needs. The 12-year-old sibling was watching the caring for the subject child and reportedly fell asleep. The subject child got outside of the home and was found wandering the street. There was an indicated report from 2016 when the subject child again got out of the home and was found by law enforcement. The mother was supervising the child at the time and failed to provide the needed supervision. There was an unfounded report from 2017 alleging the mother failed to meet the child's medical needs given her multiple medical conditions. MCDHS determined the mother provided the necessary medical treatment and conferenced with medical personnel who confirmed.

Known CPS History Outside of NYS

There was no known history outside of New York State.

Preventive Services History

A Preventive Services case was opened from 4/11/18 to 6/20/19 due to a previous report of educational neglect against the mother for the subject child and siblings. The subject child had special needs and the mother regularly left her in the care of the siblings. The siblings' educational needs were not being met as they were caring for the subject child and frequently

truant from school. An Article 10 Neglect Petition was filed in family court and the mother was ordered to comply with conditions. The Preventive Services case closed on 6/20/19, once the court orders expired.

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