Child Fatality Report

Report Identification Number: SV-25-002

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

Issue Date: May 08, 2025

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

- ☒ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.
- ☐ The death of a child for whom child protective services had an open investigation or a CPS monitored services case.
- ☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.
- ☐ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services	DA-District Attorney	
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	SXTF-Sex Trafficking
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		

Case Information

Report Type: Child Deceased
Age: 6 month(s)
Jurisdiction: Suffolk
Gender: Male
Date of Death: 01/05/2025
Initial Date OCFS Notified: 01/05/2025

Presenting Information

An SCR report received on 1/5/25 alleged that on 1/4/25, the mother put the subject child down to sleep on a mattress next to her, which was their regular practice. At approximately 6:40AM, the mother's paramour observed the child face-down on the mattress, with his face in the comforter. The mother was sleeping on the opposite side of the mattress. The child was unresponsive, and the mother woke to the paramour's scream. The mother immediately called 911. The paramour performed cardiopulmonary resuscitation (CPR) until emergency medical services (EMS) arrived. Upon arrival, EMS pronounced the child deceased. The child was transported to the hospital. It was alleged the unsafe sleeping condition contributed to the child's death. A duplicate report was received on 1/6/25 describing the same fatal incident.

Executive Summary

This report concerns the death of the 6-month-old male subject child. Suffolk County Department of Social Services (SCDSS) received two SCR reports regarding the child's death. At the time of the child's death, he resided with his mother, sibling (7), and sibling's father (hereinto referred to as the paramour). The child's father resided separately and was not involved in his day-to-day caretaking.

On 1/4/25, around 8:30PM, the mother put the child down to sleep for the night. The child shared a bed with the mother, which was a queen-sized mattress placed on the living room floor. Due to past injuries, the mother found it difficult to go up and down stairs, so the family had moved the mattress to the floor, creating easier access to the kitchen which was needed throughout the night to prepare the child's bottles. The child went to bed at his typical time, and woke around 1:00AM on 1/5/25 for a bottle, which was normal. The mother fed the child and went back to sleep. The paramour (who slept in the sibling's bedroom) woke shortly after and checked on them and observed the child on his back in the middle of the mattress. Normally, the paramour would wake at 4:00AM for work, but as he had the day off, he did not wake again until sometime after 6:00AM, at which point he observed the child face-down, with his face in the comforter. The paramour woke the mother, and quickly moved the child to the floor and began CPR, "but he was far too gone." The mother called 911 at 6:52AM. Law enforcement took over CPR upon arrival. EMS arrived and the child was pronounced deceased at the home at 7:04AM. Per protocol, the child was transported to the hospital. The hospital confirmed the absence of a heartbeat and respirations. Per hospital staff, the child already presented with rigor mortis upon EMS arrival at the home.

The medical examiner was notified and performed an autopsy on the child. The cause and manner of death were pending at the time the CPS investigation was closed. It was noted the child had a complicated medical history with multiple diagnoses and was followed by multiple medical specialties. The medical examiner stated it was unknown what the child's life expectancy was due to these issues. Preliminary findings showed no congenital anomalies, no injuries, and [mottled] airless lungs with consolidation. Law enforcement investigated. No criminality was suspected, and they were awaiting final autopsy report results.

SCDSS substantiated Inadequate Guardianship against the mother and paramour. Both adults consistently failed to exercise safe sleeping practices with the child, as either one of them would share the bed with the child on a nightly basis. SCDSS substantiated DOA/Fatality against both adults as well, citing their failure to exercise safe sleep practices was a

contributing factor in the child's death. Extensive collateral contact was made with the child's multitude of medical providers. It was noted the child demonstrated below age expected skills in multiple areas, specifically motor development. SCDSS referenced information from the child's medical records, which indicated he was working on rolling over, but could not yet lift his head. The child's delayed development increased the danger posed by bedsharing. As the medical examiner had not yet determined the cause of death, SCDSS made a causation determination based on the facts available at the time.

SCDSS made several home visits, and the sibling was assessed to be safe in the care of the mother and paramour (his father).

The family accepted resources on bereavement 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:
While it was appropriate to indicate the investigation, there were missed opportunities to further support the determination by eliciting more information from medical collaterals regarding the position of the child when found unresponsive.

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: 01/05/2025 **Time of Death:** 07:04 AM

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

County where fatality incident occurred: Suffolk
Was 911 or local emergency number called? Yes
Time of Call: 06:52 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? Unknown
Child's activity at time of incident:

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

Total number of deaths at incident event:
Children ages 0-18: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Male	6 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	33 Year(s)
Deceased Child's Household	Mother's Partner	Alleged Perpetrator	Male	39 Year(s)
Deceased Child's Household	Sibling	No Role	Male	7 Year(s)
Other Household 1	Father	No Role	Male	44 Year(s)

LDSS Response

On 1/5/25 and 1/6/25, SCDSS received SCR reports regarding the death of the subject child. SCDSS initiated their investigation within 24 hours and coordinated their efforts with law enforcement. SCDSS contacted the sources of the reports, completed a CPS history check regarding the family which revealed prior unfounded history, and informed the DA of the fatality. SCDSS assessed the safety of the sibling and conducted a home visit the same date the initial report was

received.

SCDSS interviewed the mother and paramour regarding the events leading up to the child's death. The night of the fatal incident, the paramour was sleeping in the sibling's bedroom, because the sibling was afraid of the dark, and the mother was sleeping in the living room with the subject child. The family had moved a mattress to the floor in the living room because it was difficult for the mother to go up and down stairs, and the child had multiple medical conditions which required their attention at night. The mother placed the child down to sleep on the mattress she shared with him around 8:30PM on 1/4/25. Around 1:00AM on 1/5/25, the mother fed the child a bottle and went back to sleep. Shortly after that, the paramour woke and checked on the child and mother. At that time, the child was asleep on his back in the middle of the bed. The paramour went back to bed, but when he woke up in the morning, sometime after 6:00AM and checked on the child, the child was observed to be face-down, with his face in the comforter. The paramour immediately woke the mother, who called 911 while the paramour began CPR.

SCDSS spoke with the medical examiner and primary care physician, who both confirmed the child had a complicated medical history and was under the care of several specialists. The primary care physician indicated the mother was very good about keeping all appointments for the child. The mother had been induced at 36 or 37 weeks and delivery was precipitous. The child was not breathing at birth, had a low APGAR score, and was admitted to the neonatal intensive care unit. The child had a positive toxicology for prescribed medication taken by the mother. Early Intervention evaluated the child, and he presented below age expectations in cognitive, adaptive, language, social skills, and motor development.

The child's father was contacted, though had no information regarding the death, nor was he aware of the child's health challenges.

In addition to medical collaterals, SCDSS spoke with the sibling's school and the family's care coordinator, neither of which had concerns for the family. The care coordinator was assisting the family with setting up in-home therapy services for the sibling, along with community respite services and crisis management as the sibling had his own behavioral challenges. The mother had engaged in therapy services as well. At the close of the CPS investigation, the autopsy report and law enforcement investigation were still pending. SCDSS used the evidence available at the time to support their determination, indicated, and closed the investigation.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Pending
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)? Yes

Was the fatality referred to an OCFS approved Child Fatality Review Team? No

SCR Fatality Report Summary

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

070531 - Deceased Child, Male, 6 Month(s)	070669 - Mother, Female, 33 Year(s)	DOA / Fatality	Substantiated
070531 - Deceased Child, Male, 6 Month(s)	070669 - Mother, Female, 33 Year(s)	Inadequate Guardianship	Substantiated
070531 - Deceased Child, Male, 6 Month(s)	070670 - Mother's Partner, Male, 39 Year(s)	DOA / Fatality	Substantiated
070531 - Deceased Child, Male, 6 Month(s)	070670 - Mother's Partner, Male, 39 Year(s)	Inadequate Guardianship	Substantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☒	☐	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

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	☒	☐	☐	☐

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving children in the household that were removed as a result of information uncovered during the fatality investigation?	☐	☒	☐	☐

Legal Activity Related to the Fatality

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

Services at the Time of and/or in Response to the Fatality

Services	Received	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A
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	☐	☐	☐	☐	☐	☒
Preventive Services	☐	☐	☐	☐	☐	☒
Other	☐	☐	☐	☐	☐	☒

Additional information, if necessary:
The family had an established care coordinator prior to the fatality, who continued to work with the family and assist with coordinating and referring the family to appropriate community-based services.

Were services offered to and/or received by siblings or other children in the household at the time of and/or in response to the fatality? Yes
Explain:
The family's care coordinator referred the sibling to in-home therapy services.

Were services offered to and/or received by parent(s) and other care givers at the time of and/or in response to the fatality? Yes
Explain:
The mother had begun therapy services prior to the CPS case closing, though services were not specific to bereavement. The mother, paramour (sibling's father), and subject child's father were all provided bereavement resources.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No

Was the child acutely ill during the two weeks before death? No

Infants Under One Year Old

During pregnancy, mother:

- ☒ Had medical complications / infections
- ☐ Misused over-the-counter or prescription drugs
- ☐ Experienced domestic violence
- ☐ Had a positive toxicology at the time of delivery
- ☐ Used marijuana
- ☐ Had heavy alcohol use
- ☐ Smoked tobacco
- ☐ Used illicit drugs
- ☒ Used prescription drugs
- ☐ Was not noted in the case record to have any of the issues listed

Infant was born:

- ☒ With a positive toxicology
- ☐ Exhibiting withdrawal symptoms
- ☐ With fetal alcohol effects or syndrome
- ☐ With none of the issues listed noted in case record

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)
11/29/2024	Sibling, Male, 7 Years	Mother, Female, 33 Years	Lack of Supervision	Unsubstantiated	No

Report Summary:
An SCR report received on 11/29/24 alleged that the mother left the sibling alone at a public library without an appropriate caretaker. As a result, the sibling was unsupervised for at least an hour and a half.

Report Determination: Unfounded

Date of Determination: 12/31/2024

Basis for Determination:
SCDSS unsubstantiated the allegation of Lack of Supervision against the mother on behalf of the sibling. Information was gathered from library staff that the mother utilized library services and staff did provide supervision to the sibling on the date in question. The sibling did not suffer any physical or mental harm while supervised by library staff. Adequate supervision was discussed.

OCFS Review Results:
Attempts to speak with the source were unsuccessful. It was learned the subject child had numerous health concerns. Safe sleep recommendations were reviewed with the family due to the subject child's age. The RAP could have been more accurately scored to represent the family's housing situation and mother's mental health; however, the family was already in receipt of community-based services to assist with addressing those needs. While the score may have changed, the outcome of the investigation would not have.

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

[redacted]

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/18/2024	Sibling, Male, 6 Years	Mother, Female, 32 Years	Inadequate Guardianship	Unsubstantiated	No
	Sibling, Male, 6 Years	Mother's Partner, Male, 38 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report received on 1/18/24 alleged that the mother and paramour (father to the sibling) lacked parenting skills and were failing to safely care for the sibling. They had a history of physical violence around the sibling. They were using the sibling against one another by involving the sibling in their possibly tragic actions and held heavy duty and depressing adult conversation in front of the sibling. They were telling the sibling very dangerous and deadly plans regarding one another, revealing scary and dangerous plans. The family was in the process of being evicted and had not found housing for the sibling. Their behavior was saddening and frightening to the sibling.

Report Determination: Unfounded | **Date of Determination:** 02/15/2024

Basis for Determination:
SCDSS did not find a fair preponderance of evidence to support the allegations. Both the mother and paramour denied the allegations, and presented a scene from a movie the sibling had quoted. The sibling revealed inconsistent statements. Overall, school attendance was good, there were no concerns noted by the sibling's pediatrician, and the family's in-home service provider denied concerns.

OCFS Review Results:
SCDSS initiated their investigation timely and conducted a home visit the day the report was received. The sibling was interviewed separately from the mother and paramour and did not provide a consistent account. SCDSS observed the scene from the movie the sibling was heard quoting, which explained the concerning statements alleged. SCDSS contacted relevant collaterals. The family was moving during the investigation and had relocated to a shelter at closing.

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

[redacted]

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
03/14/2022	Other Child - Adopted Child, Female, 17 Years	Mother, Female, 31 Years	Inadequate Guardianship	Unsubstantiated	No
	Other Child - Adopted Child, Female, 17 Years	Mother's Partner, Male, 36 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
An SCR report received on 3/14/22 alleged that in October 2020, the mother and her paramour's adopted 17yo child left the household because the mother was physically abusing her. Around Christmas 2016, the mother cornered the 17yo and held a knife to her and had also hit her in the face. The mother and paramour were aware of the 17yo's whereabouts and refused to allow her back into their care and refused to make an adequate plan for her care. The mother and paramour were not financially supporting the 17yo, nor providing her with personal legal documents.

Report Determination: Unfounded | **Date of Determination:** 05/15/2022

Basis for Determination:
The 17yo child left the home of the adoptive parents over one year prior to the SCR report. The 17yo received the required documentation from her law guardian. The 17yo did not wish to return to her adoptive home and reported

feeling safe in the care of her mother. Law enforcement was called and denied being able to compel the 17yo to return to the adoptive home.

OCFS Review Results:
The mother, paramour, birth mother, and 17yo were interviewed. The mother and paramour confirmed the 17yo could return home if she wanted and had been advised by legal counsel to not release legal documents to the 17yo's mother. The record reflected the 17yo was adopted in 2019 by the subject mother and paramour, but at the time the SCR report was made, the 17yo had been placed via Article 6 (as of 7/12/2021) with a stepmother.

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

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

The family had additional unfounded history with SCDSS.

11/28/20 – 2/4/21 The mother and paramour were unsubstantiated for allegations of Emotional Neglect, Inadequate Food/Clothing/Shelter, Inadequate guardianship, and Parent's Drug Alcohol Misuse regarding their now adult adopted child.

4/26/19 – 6/21/19 The paramour was unsubstantiated for allegations of Inadequate Guardianship and Sex Abuse regarding another child not included in this report for whom the mother and paramour temporarily had custody of.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

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