Child Fatality Report

Report Identification Number: NY-23-065

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

Issue Date: Dec 01, 2023

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 year(s)
Jurisdiction: Kings
Gender: Female
Date of Death: 06/21/2023
Initial Date OCFS Notified: 06/21/2023

Presenting Information

An SCR report received on 06/21/23 alleged that on 06/17/23, the 6-year-old child sustained burns covering 50% of her body, including on her thighs, back, torso and arms. The mother was home with the child when the child sustained the burns. The mother reported the child sustained the burns by leaning on a hot kitchen stove. The explanation was inconsistent with the child's injuries. As a result of the child's injuries, she was pronounced deceased on 06/21/23 at 7:20 AM. The report was subsequent to an investigation that began on 06/17/23, which concerned the fatal incident.

Executive Summary

This report concerns the death of the 6-year-old child that occurred on 06/21/23. The child died as a result of injuries sustained from a fire. A report was made to the SCR on the day of her death, as well as on the day of the fatal incident, 06/17/23. At the time of the child's death, she resided with her parents and siblings, aged 15, 12, 10, 8, and 4 years. The siblings were assessed to be safe.

The Administration for Children's Services (ACS) coordinated investigative efforts with law enforcement upon receipt of the SCR report. The criminal case was closed without charges filed. Due to the family's religious beliefs and circumstances surrounding the death, an autopsy was not performed; however, an external examination was completed. The child's cause of death was "thermal burns of torso, head, and extremities." The manner of death was an accident.

ACS gathered information that on 06/17/23, the father and the male siblings were out of the home while the mother was home with the child and female siblings. Due to the family's religious beliefs, their gas stove was left on with an aluminum cover over the burner. The child was in the kitchen when the mother and 15-year-old sibling heard screaming and went to the kitchen. The child was engulfed in flames and the mother instructed the child to go outside, and stop, drop, and roll. An ambulance was called, and the child was transported to the hospital where she died on 06/21/23. The parents and siblings reported the children were warned on multiple occasions to not touch the stove and that they were always supervised.

ACS made home visits and documented thorough interviews with family members, a friend, and members of the community. There were concerns the mother and 15-year-old sibling fighting; however, it was determined the sibling was safe. There were concerns regarding supervision of all the children and that they and the home were dirty; however, the family denied this, and the children were not observed to be dirty. The home was not accessible due to fire damage; therefore, the siblings were residing with family members and friends until they obtained housing assistance from a community-based resource.

The Safety Assessments completed reflected a Safety Decision #3, reflecting the SSs were in immediate or impending danger of harm; however, the information used to make that decision were risk, and not safety factors. The Risk Assessment Profile was completed inaccurately as it did not reflect the child died as a result of abuse or maltreatment.

The allegations of Lack of Supervision, Inadequate Guardianship, Burns/Scalding and DOA/Fatality were substantiated against the mother. The Investigation Conclusion Narrative noted that due to religious beliefs, the family left a stove burner on. The child was able to access the burner and caught on fire. The mother immediately responded to the child screaming and assisted her in extinguishing the flames and an ambulance was called. The child sustained burns about her body and as a result, subsequently died.

The family was offered and accepted bereavement counseling. A Preventive Services Case was opened on 06/26/23 as community members had concerns for the supervision of the children and the 15-year-old sibling's behaviors.

PIP Requirement
ACS will submit a PIP to the New York City Regional Office within 45 days of the receipt of this report. The PIP will identify action(s) the ACS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ACS will review the plan and revise as needed to address ongoing concerns.

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?** No

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 remained open for services.

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

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? No

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
Casework activity was not commensurate with case circumstances as the Safety Assessments and Risk Assessment Profile did not accurately reflect case circumstances.

Required Actions Related to the Fatality

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

Issue:	Adequacy of Documentation of Safety Assessments

Summary:	Safety Assessments were inaccurate as they reflected a Safety Decision #3; yet the case notes did not reflect the children were immediate or impending danger of harm. The Safety Assessments were completed with regard to risk rather than safety.
Legal Reference:	18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)
Action:	The results of each Safety Assessment must be accurately documented in the case record to reflect case circumstances regarding safety.
Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	The Risk Assessment Profile was completed inaccurately. Although the allegation of DOA/Fatality was substantiated, ACS documented the SC's death was not the result of abuse or maltreatment.
Legal Reference:	18 NYCRR 432.2(d)
Action:	ACS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 06/21/2023 **Time of Death:** 07:20 AM

Date of fatal incident, if different than date of death: 06/17/2023
Time of fatal incident, if different than time of death: 09:30 PM

County where fatality incident occurred: Kings
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used and/or ingested alcohol or drugs? No
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	Female	6 Year(s)
Deceased Child's Household	Father	No Role	Male	39 Year(s)

Deceased Child's Household	Mother	Alleged Perpetrator	Female	37 Year(s)
Deceased Child's Household	Sibling	No Role	Male	4 Year(s)
Deceased Child's Household	Sibling	No Role	Male	8 Year(s)
Deceased Child's Household	Sibling	No Role	Female	10 Year(s)
Deceased Child's Household	Sibling	No Role	Male	12 Year(s)
Deceased Child's Household	Sibling	No Role	Female	15 Year(s)

LDSS Response

On 06/21/23, ACS received the fatality report from the SCR. The report was subsequent to an investigation that began on 06/17/23 regarding the fatal incident. Within the first 24 hours of the investigation, ACS contacted the source of the report, coordinated investigative efforts with law enforcement, notified the medical examiner and district attorney's offices of the death and documented a CPS history check. ACS was aware the surviving children were staying with family members as their home was under investigation due to the fire.

Prior to the death, ACS obtained information from collateral contacts and family members. Hospital staff reported that the child sustained second and third degree burns to nearly 50% of her body and that she was in critical condition.

LE reported the incident was accidental and that no arrests were made. LE provided information from the fire marshal who reported the SM's reenactment was consistent with the SC's injuries.

The SM was interviewed and stated that due to the family's religion, at times the stover burner is left on with an aluminum cover on top of it. On 06/17/23, the SC went into the kitchen. A few minutes later, the SM heard a loud scream, and she went into the kitchen and saw the SC was on fire. She instructed the SC to stop, drop and roll, and then called EMS. The SM reported throwing water on the SC but could not remember further details. The SM asked the SC what happened; however, the SC was unconscious. The SM reported this was the first time the child used the stove, and that she never left the children unattended. The SM reported the SSs were staying with relatives due to damage of the fire.

On 6/20/23, the BF and siblings were interviewed. The BF was out of the home with the 3 male SSs until 10:00 PM on 06/17/23, and he learned about the fire when they returned home. He reported the SC listened to the parents, and that she was obedient. The BF said the children were always supervised. The younger SSs were interviewed privately. The 10yo SS was outside at the time of the fatal incident and saw the SC come outside and that she was on fire. The 15yo SS was in her room when she heard screaming and saw the SC on fire. Her recollection was consistent of the SM's. The 8 and 12yo SSs said they were told not to go near the stove and that they were always supervised. The 4yo SS did not engage in conversation.

On 06/21/23, hospital staff notified ACS of the death. The SC was reported to have gone into cardiac arrest due to the severity of her injuries.

A home visit was made following the death and the family was interviewed. Their recollections of the incident remained consistent.

ACS interviewed a community member who reported concerns for the behavior of the 15yo SS, including not following curfew, and concerns the SM did not supervise the children. It was alleged the SM would leave 15yo SS in charge of the children; however, the SS would leave the home and would hit the other children. This information was not confirmed during the investigation. ACS interviewed a neighbor, a community member and a family friend who did not report concerns for the safety of the children.

After completing all casework activity, the investigation was determined. The case remained open for preventive services.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From an injury - external cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

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

Was the fatality referred to an OCFS approved Child Fatality Review Team?No
Comments: New York City does not have an OCFS-approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
065308 - Deceased Child, Female, 6 Yrs	065309 - Mother, Female, 37 Year(s)	DOA / Fatality	Substantiated
065308 - Deceased Child, Female, 6 Yrs	065309 - Mother, Female, 37 Year(s)	Burns / Scalding	Substantiated
065308 - Deceased Child, Female, 6 Yrs	065309 - Mother, Female, 37 Year(s)	Inadequate Guardianship	Substantiated
065308 - Deceased Child, Female, 6 Yrs	065309 - Mother, Female, 37 Year(s)	Lack of Supervision	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?				

Additional information:
The 4yo SS did not engage with ACS.

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?	☐	☒	☐	☐
Explain as necessary: The siblings did not need to be removed as a result of 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 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	☐	☐	☐	☐	☐	☒	☐
Additional information, if necessary: The parents utilized community members and relatives to help care for the children while they processed the death. A Preventive Services Case was opened.							

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 mother reported the family received support through their community.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The parents accepted bereavement services through their community and Comfort Help.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
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)
06/17/2023	Sibling, Male, 4 Years	Other Adult - Caregiver, Female, 29 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Sibling, Male, 4 Years	Other Adult - Caregiver, Female, 29 Years	Internal Injuries	Unsubstantiated	
	Sibling, Male, 4 Years	Other Adult - Caregiver, Female, 29 Years	Lacerations / Bruises / Welts	Unsubstantiated	
	Sibling, Male, 4 Years	Other Adult - Caregiver, Female, 29 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Male, 4 Years	Other Adult - Caregiver, Female, 29 Years	Swelling / Dislocations / Sprains	Unsubstantiated	
	Deceased Child, Female, 6 Years	Mother, Female, 37 Years	Burns / Scalding	Unsubstantiated	
	Deceased Child, Female, 6 Years	Mother, Female, 37 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Female, 6 Years	Mother, Female, 37 Years	Lack of Supervision	Substantiated	

Report Summary:
An SCR report alleged that on 06/17/23, a gas stove caught on fire in the home while child was in close proximity. The child's clothing caught on fire. The mother instructed the child to stop, drop, and roll to put the fire out and the child sustained second and third-degree burns covering 50% of her body. The mother's explanation was inconsistent with the injuries. A subsequent report received on 07/23/23 alleged the caregiver did not ensure the 4yo SS wore a helmet and did not supervise him while riding a scooter. The SS fell and sustained marks and bumps to his head and arm. The SS sustained a concussion, vomited and was in and out of consciousness.

Report Determination: Indicated | **Date of Determination:** 08/16/2023

Basis for Determination:

The SM was substantiated for IG and LS as she did not supervise the SC around the ignited stove and as a result, the SC sustained burns that ultimately caused her death. The allegation of B/S was unsubstantiated. The Investigation Conclusion Narrative stated there was not a fair preponderance of evidence that the SM failed to provide adequate care to the SC and that the burns were accidental. Allegations of IG, II, S/D/S and L/B/W were unsubstantiated against the caregiver regarding the 4yo SS. The SS fell off a scooter and sustained a scratch to his arm. The caregiver sought medical attention immediately. The SS was supervised when he fell off the scooter.

OCFS Review Results:

The investigation was initiated timely, the source was contacted, and a CPS history check was documented. home visits were made, and interviews were appropriate. The Safety Assessment completed at the time of case closure and Risk Assessment Profile were inaccurate. Allegations against the SM and caregiver were inappropriately determined. The record reflected the SS fell off a scooter and was injured. He sustained a concussion, vomited and scratched his arm. The caregiver sought medical attention immediately.

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

Issue:

Adequacy of Documentation of Safety Assessments

Summary:

The Safety Assessments completed at the time the investigation was determined was inaccurate as it reflected a Safety Decision #3, yet the notes did not reflect the children were immediate or impending danger of harm. The Safety Assessments were completed with regard to risk factors rather than current safety concerns.

Legal Reference:

18 NYCRR432.2(b)(3)(ii)(c)&(iii)(b)

Action:

The results of each Safety Assessment must be accurately documented in the case record to reflect case circumstances regarding safety.

Issue:

Adequacy of Risk Assessment Profile (RAP)

Summary:

The Risk Assessment Profile was completed inaccurately as it reflected the parents had developmentally appropriate expectations of the children; however, the child died as a result of burns she sustained while she was not properly supervised around an open flame. The Risk Assessment Profile did not reflect the child died as a result of abuse/maltreatment.

Legal Reference:

18 NYCRR 432.2(d)

Action:

ACS will consider all risk elements identified throughout the course of the investigation and accurately document such elements into the Risk Assessment Profile.

Issue:

Appropriateness of allegation determination

Summary:

The allegations of II and IG were unsubstantiated against the caregiver despite the SS not wearing a helmet and sustaining a concussion as a result. The allegation of B/S was inappropriately unsubstantiated against the SM as the SC was hospitalized and ultimately died as a result of being burned. Contradictorily, the allegation B/S was substantiated in the concurrent investigation.

Legal Reference:

FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)

Action:

ACS will refer to the CPS Program Manual when determining the appropriateness of allegations and will consult with the New York City Regional Office if further guidance is needed.

[redacted]

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

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

Known CPS History Outside of NYS

There is no known CPS history outside of New York.

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