Office of Children and Family Services

Child Fatality Report

Report Identification Number: RO-18-009

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

Issue Date: Aug 30, 2018

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

☒ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☐ The death of a child for whom child protective services has an open case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☐ The death of a child for whom the local department of social services has an open preventive service case.

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

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

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

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

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

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

Abbreviations

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

Case Information

Report Type: Child Deceased
Age: 14 year(s)
Jurisdiction: Monroe
Gender: Male
Date of Death: 03/11/2018
Initial Date OCFS Notified: 03/14/2018

Presenting Information

On 3/14/18, an SCR report was received alleging that the Parent Substitute (PS) physically beat the 14yo SC. The report further alleged the SM was aware of the abuse, yet failed to intervene to protect the SC from being harmed by the PS. On the morning of 3/8/18, the SC went to school and was marked in for attendance. Shortly after arriving at school, the SC left and walked to the river, where he jumped in, committing suicide. The report alleged the SC committed suicide as a result of the physical abuse he was enduring by the PS. On the evening of 3/8/18, the SC was reported missing by the SM. On 3/11/18, the SC's body was discovered in the river by LE. On 3/11/18, the SC was pronounced dead at 7:00 PM. It was alleged the the 11yo SS was also being beaten by the PS in the same manner that the SC was.

Executive Summary

On 3/14/18, Monroe County Department of Human Services (MCDHS) responded to an SCR report concerning the death of a 14yo male SC. SC's death which occurred between 3/8/18, when the SC was reported missing and when the SC was found in the river on 3/11/18. The allegations in the report stated on 3/8/18, the SC had lost his cell phone and had been told by the PS if he arrived home from school that day without the phone he would be beaten. The report alleged the SC threatened to kill himself if he did not find his phone.

On 3/11/18, the SC was found in the river and was deceased. LE reported the SC had been reported missing on 3/8/18, when he did not arrive home from school. LE learned the SC had been marked in attendance that day but it was believed he left school some time the day. After several days of searching a dive team found the SC in the river.

MCDHS went out to the home on 3/14/18, to assess the safety of the SS but were denied access to the SS and the home by the SM and the PS. MCDHS called LE for assistance but were still denied access. MCDHS were provided with the name and phone number of the SM’s attorney. MCDHS consulted with their legal department about filing an access order to have the SM produce the SS. Subsequently, the SM agreed for the SS to be interviewed at her attorney’s office. Present during the interviews were MCDHS’s attorney, MCDHS caseworker and the SM’s attorney. The SS denied feeling unsafe at home and denied the SM or the PS harmed or threatened them. MCDHS was not permitted by the SM attorney to ask questions about the SC.

The ME’s report was not completed and the cause and manner of death were still pending at the time of the writing of this report.

MCDHS gathered information from collaterals, such as the SM, family members, LE and follow up visits were made to the SS’s school where the SS’s were re-interviewed. The SM refused to sign releases; this limited the information that MCDHS had access to. At the time this report was written, the LE investigation was ongoing and there were no arrests.

MCDHS unsubstantiated the allegations of Inadequate Guardianship against the SM and the PS for the SC and the 11yo SS. The SS’s denied that the SM ever harmed them or the SC. They denied that the SM allowed the PS to harm or threaten them or the SC. An unrelated home member (URHM) was interviewed and denied the SM or PS ever harmed her children and said she was a good mother. A cousin of the SC was interviewed and he denied that the SC had ever said the PS had physically harmed him. Other family members were interviewed who voiced concerns for the care of the SC and SS but had not witnessed the PS or the SM physically harm the SS or the SC. LE investigation was on-going and it was still

undetermined whether the SC had intended to jump into the river as a means of committing suicide.

MCDHS unsubstantiated the allegations of DOA/Fatality against the PS for the SC. There was no evidence the support that the PS caused the SC's death based on the interviews and information gathered. MCDHS unfounded the report and the case was closed. MCDHS offered services several times to the SM and the PS, they refused 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

Explain:
MCDHS made numerous attempts to engage the family and to offer appropriate referrals to meet the needs of all family members. The SM and the PS refused to fully cooperate with MCDHS.

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:
MCDHS was able to adequately assess the safety of the SS even though the SM and the PS refused to fully cooperate with MCDHS. MCDHS made several attempts to engage the family and offer appropriate referrals for bereavement services.

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: 03/11/2018 **Time of Death:** Unknown

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: Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? No
Child's activity at time of incident:

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

Did child have supervision at time of incident leading to death? No - Not needed given developmental age or circumstances

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	14 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	39 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)
Deceased Child's Household	Sibling	Alleged Victim	Female	12 Year(s)
Deceased Child's Household	Sibling	No Role	Male	8 Year(s)
Deceased Child's Household	Sibling	No Role	Male	17 Year(s)
Other Household 1	Father	No Role	Male	43 Year(s)

LDSS Response

On 3/14/18, MCDHS received an SCR report concerning the SC's death which occurred between 3/8/18, when the SC was reported missing, and when the SC was found in the river on 3/11/18. MCDHS initiated their investigation by contacting LE and ME. An SCR history check was completed. MCDHS conducted searches and made attempts to locate and speak with the BF who resided out of state but were unsuccessful. A Notice of Existence letter was sent to the last known address for the BF.

MCDHS conducted a 24-safety assessment. Initially the SM and the PS refused access to the home and the SS. MCDHS consulted with their legal department about filing an access order. Later in the day the SM gave permission for the SS to be interviewed at her attorney's office. MCDHS was instructed by the SM attorney to only ask questions relevant to the safety of the SS and not ask questions about the events leading up to the death of the SC. MCDHS conducted interviews of the SS and the URHM. The SS told MCDHS that they felt safe at home and denied the SM and the PS had ever harmed them or the SC. URHM reported no concerns for the care of the SS. MCDHS observed the SS and they had no visible marks or bruises.

Through interviews with collateral contacts, family members and LE, MCDHS learned that the SC had gone to school on 3/8/18 and sometime during the day he left school. The SM reported the SC missing the evening of 3/8/18. On 3/11/18 the SC was found in the river by first responders. The SM and the PS were not fully cooperative with MCDHS and the SM refused to sign releases. The SM and the PS refused to talk about the events leading up to the SC's death based on the advice of their attorney but did denied any drug/alcohol misuse and denied threatening or harming the SC. LE investigation was ongoing and there was no evidence whether or not the SC jumped into the river. There were no arrests.

While family members reported concerns to MCDHS about the care of the SC and the SS, none of them had witnessed the SM or the PS harming the SS or the SC. MCDHS made follow up visits to the home but were denied access. MCDHS conducted follow up interviews with the SS at school and no new information was learned. The SS denied being harmed and denied the SM or the PS had harmed or threatened the SC. MCDHS offered bereavement referrals to family members. At the time of the writing of this report the SM refused services.

The preliminary findings from the ME's office were still pending at the time of the writing of this report.

Official Manner and Cause of Death

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

Multidisciplinary Investigation/Review

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

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
047341 - Deceased Child, Male, 14 Yrs	047342 - Mother, Female, 39 Year(s)	Inadequate Guardianship	Unsubstantiated
047341 - Deceased Child, Male, 14 Yrs	047344 - Mother's Partner, Male, 39 Year(s)	Inadequate Guardianship	Unsubstantiated
047341 - Deceased Child, Male, 14 Yrs	047344 - Mother's Partner, Male, 39 Year(s)	DOA / Fatality	Unsubstantiated
047346 - Sibling, Female, 12 Year(s)	047342 - Mother, Female, 39 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?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate safety assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☒	☐	☐	☐

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine

Was the risk assessment/RAP adequate in this case?	☒	☐	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐
Explain: The SM and the PS refused to cooperate and refused services.				

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: The SS were not removed.				

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	☐	☐	☐	☐	☐	☒	☐

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? No
Explain:
MCDHS offered appropriate referrals for bereavement services to the SS.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
MCDHS offered appropriate referrals for bereavement services to all family members.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? Yes
Was there an open CPS case with this child at the time of death? No
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? Yes
Was the child acutely ill during the two weeks before death? No

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
05/04/2017	Deceased Child, Male, 13 Years	Mother, Female, 38 Years	Inadequate Guardianship	Far-Closed	Yes

Report Summary:
The SC had a history of suicidal ideation. The SC continuously had thoughts of dying, or put himself in a situations where he would be killed. The SM was aware of the risk the child was to himself, and did not ensure these concerns were addressed appropriately. Roles of the SS were unknown. The BF's role was unknown.

OCFS Review Results:
The OCFS review showed the source of the report was never contacted. MCDHS had conducted an SCR history check for NYS; however, MCDHS never contacted Texas or Arkansas as to whether there was any history on this family, as it was known they previously resided in those states. This could have provided MCDHS with relevant information about the family as a collateral contact.

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

Issue:
FAR-Failure to Contact the Source

Summary:
MCDHS never contacted the source.

Legal Reference:
18 NYCRR 432.13 (d)(1)(i)

Action:
OCFS authorization of Monroe County FAR was suspended on 4/6/18 and MCDHS has informed OCFS that they have no intention of re-engaging in the FAR Program; therefore no Program Improvement Plan required.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
10/03/2016	Deceased Child, Male, 12 Years	Mother, Female, 37 Years	Lack of Medical Care	Unsubstantiated	Yes
	Deceased Child, Male, 12 Years	Mother, Female, 37 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
The SCR report alleged the SC had a history of mental health problems with suicidal ideations. The SM was aware of the SC's mental health and had not provided him with any mental health services. As a result, the SC's mental health had worsened and he continued to have thoughts of suicide with a plan. The roles of the SS were unknown.

Report Determination: Unfounded **Date of Determination:** 02/11/2017

Basis for Determination:
MCDHS unsubstantiated the allegations of IG and LMC against the SM for the SC. The determination was based on interviews with the SS, SC and the SM. The SM denied knowing that her son was suicidal. The SC denied wanting to hurt himself. The home was observed to be neat and clean and free from safety hazards. MCDHS made a referral to assist the family in obtaining some furniture and recommended counseling for the SC. The case was UNF and closed. There were no further services needed.

OCFS Review Results:
MCDHS only made one attempt to contact the source, and the source was never spoken to. MCDHS only made one attempt to assess the safety of the SS and the SC within the 24 hours. The SS and the SC were not seen for 3 days after the report was received. There was no information in the case record about when the SC was released from the hospital or what the recommendations were upon the SC's release. The SM was not provided with the Notice of Existence letter with in the 7 day required time frame. Attempts to locate the BF were made but were unsuccessful.

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

Issue:
Timely/Adequate 24 Hour Assessment

Summary:
MCDHS failed to assess the safety of the SC and the SS within the 24hr time frame as per regulation.

Legal Reference:

SSL 424(6);18 NYCRR 432.2(b)(3)(i)

Action:

MCDHS will assess the safety of all children residing in the home within the required time frames.

Issue:

Contact/Information From Reporting/Collateral Source

Summary:

MCDHS only made one attempt to contact the source of the report and this was done two days after the report was made to the SCR. The source may have had relevant information about the immediate safety of the SC.

Legal Reference:

18 NYCRR 432.2(b)(3)(ii)(b)

Action:

MCDHS will contact the source of the report, if known as per regulation.

Issue:

Failure to provide notice of report

Summary:

MCDHS failed to provide the notice of the report within the 7 day required time frame.

Legal Reference:

18 NYCRR 432.2(b)(3)(ii)(f)

Action:

MCDHS will provide notice of report within the required time frame per regulation.

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

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

Known CPS History Outside of NYS

MCDHS contacted CPS in Arkansas and they were unable to identify any records regarding the subjects of the request at that time.

MCDHS contacted CPS in Texas and there was one unfounded case dated 4/11/13 in regards to excessive corporal punishment of a SS by the SM. The SS and the SM were interviewed and the case was unfounded. The BF and the other SS and the SC were not listed on the case.

Preventive Services History

On 5/14/15, a preventive referral was made by Monroe County Probation Department requesting services. The SS was a learning disabled youth and required educational support. The SS had some JD behaviors. The case was opened for Preventive services and closed on 11/14/15, stating the goals were achieved. The case was a PINS/diversion program. The SS completed probation in Sept. of 2015 and his participation in the program being provided was voluntary from Sept. until case was closed.

On 7/13/16, a preventive case was opened as the result of a referral from probation in regard to the SS. The SS attended a day program and fully participated. The case was closed on 12/2/16 and goals were achieved.

Foster Care Placement History

On 3/30/17, the SS was placed under probation's juvenile intensive supervision due to the following concerns: The SS had been adjudicated on three separate charges of theft. The SS was skipping classes and he was failing school as a result. On 4/1/17 the SC AWOL'd from home. A violation of probation was filed on 4/10/17, with a warrant request. The SS was picked up on the warrant on 4/14/17 and was remanded to the secure detention by the Family Court Judge. The SS made an admission on 4/14/17 in Family Court and was placed in residential care under MCDHS custody on all three juvenile delinquent dockets. The SS remained in care until after the reported death of the SC. After the death of the SC the SM requested the the SS court order be terminated and this was granted by the Family Court Judge on 4/3/18. The SS returned home to live with the SM and the other SS. The family was offered Preventive Services and they declined services.

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

Additional Local District Comments

“Monroe County has reviewed this report, we find this report to be factually accurate”.

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