



Report Identification Number: SV-23-017

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

Issue Date: Jun 29, 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: 2 year(s)

Jurisdiction: Orange
Gender: Female

Date of Death: 04/07/2023
Initial Date OCFS Notified: 04/07/2023

Presenting Information

An SCR report alleged on April 7, 2023, around 12:00AM, the subject mother and subject father put the 2-year-old subject child to bed after she was playing with her 4 and 6-year-old surviving siblings. Prior to sending the child to bed, the mother and father gave the subject child strawberry milk. The father checked on the subject child at 9:23AM and found her unresponsive, facedown on her pillow, with pink mucous in her nose. The mother contacted 911 while the father performed cardiopulmonary resuscitation on the child until law enforcement arrived. When law enforcement arrived, they continued resuscitation attempts on the subject child with no success. Emergency medical services responded to the home and pronounced the subject child dead at the residence.

Executive Summary

This report concerns the death of the 2-year-old child that occurred on April 7, 2023. Orange County Department of Social Services (OCDSS) received an SCR report on April 7, 2023, regarding the fatality. The report contained allegations of DOA/Fatality and Inadequate Guardianship against the mother and father of the subject child. The subject child was an otherwise healthy child and there was no explanation for her sudden death. At the time of her death, the subject child resided with her mother, father and two siblings ages 6 and 4-years-old. OCDSS immediately assessed the safety of the surviving siblings, interviewed the children, and assessed the residence where they were staying. OCDSS implemented a short-term safety plan that the parents would be supervised by family members until further information was obtained from the medical examiner.

Through a joint investigation with law enforcement, it was learned on April 6, 2023, the mother, father, subject child and surviving siblings were at their family residence for the evening. The subject child and 4-year-old surviving sibling were both reported to have been ill. The subject child slept through most of the evening and was seen awake at 12:00AM on April 7, 2023. The subject child was checked on at 12:20AM by her father and was observed to be sleeping next to her 6-year-old sibling in the living room.

Contrary to the presenting information, at 9:00AM the subject mother observed the subject child facedown on a pillow with her buttocks in the air and her skin color was blue. The subject mother and father attempted CPR and contacted 911; however, when emergency medical services arrived at the residence, they pronounced the child deceased at 9:26AM.

OCDSS communicated with law enforcement throughout the investigation and learned there were no criminal charges pending against the parents. In addition, at the time the autopsy was performed there were no signs of abuse or maltreatment. Furthermore, law enforcement spoke with the medical examiner who indicated the subject child had pulmonary edema. At the time this report was written, the final autopsy report was still pending but toxicology had been received and was negative. The allegations of DOA/Fatality and Inadequate Guardianship against the mother and father were unsubstantiated. OCDSS found there was not a fair preponderance of evidence to support the above allegations and the case was closed on May 24, 2023.

The record reflected OCDSS completed their investigation, required reports and safety assessments timely and accurately. The risk assessment was reflective of case circumstance and several visits were completed with the family.

OCDSS offered burial assistance and referred the family for grief counseling, both services the family accepted. OCDSS gathered pertinent information from collateral contacts such as the children’s pediatrician, school, medical staff, law



enforcement and the paternal grandmother. Casework staff assisted the family with notifying the surviving siblings' school and daycare regarding the sudden loss of the subject child and arranged for the 6-year-old surviving sibling to receive additional mental health services at school.

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:

OCDSS made an appropriate determination based on evidence gathered throughout the investigation.

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 circumstances.

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: 04/07/2023

Time of Death: 09:26 AM



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

Unknown

County where fatality incident occurred:

Orange

Was 911 or local emergency number called?

Yes

Time of Call:

09:00 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	Female	2 Year(s)
Deceased Child's Household	Father	Alleged Perpetrator	Male	26 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	28 Year(s)
Deceased Child's Household	Sibling	No Role	Male	6 Year(s)
Deceased Child's Household	Sibling	No Role	Male	4 Year(s)

LDSS Response

On April 7, 2023, OCDSS received a report regarding the death of the SC. OCDSS initiated their investigation within 24 hours and coordinated their efforts with law enforcement. OCDSS contacted the source of the report, reviewed prior CPS history regarding the family and promptly notified the Medical Examiner and District Attorney. OCDSS interviewed the subjects of the report with law enforcement and assessed the safety of the surviving siblings.

OCDSS interviewed the SM who reported that the night prior to the death the SC took a nap from 3:30PM to 6:30PM and ate dinner immediately following her nap. The SM noted the child did not eat her normal portion at dinner and around 7:00PM the SC went back to sleep in the living room. At approximately 7:30PM the SM noticed the SC was sweating in her sleep, so the SM changed her into a nightgown. During this time, the SM administered 5ml of liquid children's Tylenol via syringe. The SM reported the SC slept in the living room on a futon until approximately 12:00AM on April 7, 2023. The SM explained she woke up at 9:00AM on April 7, 2023, and observed the SC facedown on a pillow with her buttocks up in the air. During her interview, the SM noted that was the SC's usual position while sleeping. The SM further reported she immediately observed the SC's color was blue and flipped her over, she screamed for the SF and then promptly contacted 911 at approximately 9:00AM. The SM stated the SF attempted CPR with no success, EMS arrived and pronounced the child deceased at the residence. The SM explained the SC had recently complained of stomach aches and had chronic constipation; the SC had pending medical appointments regarding these issues. The SM denied the child had recently inhaled or ingested anything unusual as well as any recent injuries to the SC.



OCDSS interviewed the SF who reported the night prior to the death he arrived home from work at approximately 5:30PM. The SC woke up from her nap, ate dinner with the family and then went back to sleep. He explained hearing the SC in the living room at 12:00AM on April 7, 2023 and proceeded to check on her. The SF told the SC and the 6-year-old SS, who was also awake, to lay down. He checked on the children again at 12:20AM and observed them sleeping. The SF reported the SC was sleeping on the futon in the living room, she was observed to be laying on her back, faceup, while the 6-year-old SS was on his side facing the SC. The SF stated he later woke up to the SM screaming for him to help the SC as she was not breathing. In response to this, the SF attempted CPR and explained when he did CPR, the SC had pink liquid coming from her mouth. The SF informed casework staff that the SC was given strawberry milk prior to bed.

OCDSS interviewed the 6-year-old and 4-year-old siblings. The 6-year-old SS reported the SC was sleeping in the living room and identified that is where the child normally sleeps. He explained the SC sleeps with her knees tucked up into her chest and described the 4-year-old SS also sleeps in the same position. He reported the SF went into the living room to wake the SC and her head was in a pillow and she was not breathing. No other details were provided concerning the incident and the 4-year-old SS did not provide any relevant information regarding the fatality.

Collateral contact with the SS's pediatrician revealed the children were up to date with their immunizations and there were no concerns for their physical health.

OCDSS observed photographs of the scene where the death occurred and noted there was pink vomit on the floor near the futon where the SC was sleeping. There were no concerns noted regarding the condition of the home as it met minimal standards. The mother and father decided to relocate following the loss of the SC and at the time this report was written, had been staying with relatives until they were able to secure a new residence.

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? Yes

Comments: Orange County referred this fatality to their OCFS approved Child Fatality Review Team.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
063433 - Deceased Child, Female, 2 Yrs	063434 - Mother, Female, 28 Year(s)	DOA / Fatality	Unsubstantiated
063433 - Deceased Child, Female, 2 Yrs	063434 - Mother, Female, 28 Year(s)	Inadequate Guardianship	Unsubstantiated
063433 - Deceased Child, Female, 2 Yrs	063435 - Father, Male, 26 Year(s)	DOA / Fatality	Unsubstantiated
063433 - Deceased Child, Female, 2 Yrs	063435 - Father, Male, 26 Year(s)	Inadequate Guardianship	Unsubstantiated



CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When appropriate, children were interviewed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alleged subject(s) interviewed face-to-face?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All 'other persons named' interviewed face-to-face?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Contact with source?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All appropriate Collaterals contacted?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was a death-scene investigation performed?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coordination of investigation with law enforcement?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there timely entry of progress notes and other required documentation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At 7 days?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At 30 days?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are there any safety issues that need to be referred back to the local district?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to
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Child Fatality Report

	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Determine
Was the risk assessment/RAP adequate in this case?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there an adequate assessment of the family's need for services?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were appropriate/needed services offered in this case	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Explain:
All family members were referred to grief counseling.

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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were there surviving children in the household that were removed as a result of information uncovered during the fatality investigation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Economic support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Funeral arrangements	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housing assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Mental health services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foster care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Legal services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Family planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Homemaking Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>



Parenting Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Domestic Violence Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Early Intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Alcohol/Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Child Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Intensive case management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Family or others as safety resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

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:

OCDSS referred the surviving siblings to grief counseling.

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

Explain:

OCDSS referred the parents to grief counseling and assisted with funeral costs.

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?

Yes

CPS - Investigative History Three Years Prior to the Fatality

There is no CPS investigative history in NYS within three years prior to the fatality.

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 history outside of New York State.

Legal History Within Three Years Prior to the Fatality



Was there any legal activity within three years prior to the fatality investigation? There was no legal activity.

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? Yes No

Are there any recommended prevention activities resulting from the review? Yes No