NYS Office of Children and Family Services - Child Fatality Report

Report Identification Number: RO-15-007 **Prepared by: Rochester Regional Office**

Issue Date: 8/3/2015

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
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
CPR-Cardio-pulmonary Resuscitation		
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	MN-Medical Neglect	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-Others	
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		

Case Information

Report Type: Child Deceased
Age: 9 month(s)
Jurisdiction: Monroe
Gender: Female
Date of Death: 01/18/2015
Initial Date OCFS Notified: 02/12/2015

Presenting Information

The initial SCR report was received on 2/12/15 and alleged that on 1/18/15 at 4:29PM, the SC was found unresponsive and pronounced dead at 5:03PM. An autopsy determined the SC had methadone in her system at the time of her death. The death was suspicious.

The subsequent SCR report was received on 2/19/15 and alleged that on 1/18/15 the SC died at the hospital. An autopsy was conducted on 1/20/15. On 2/11/15, the SC's toxicology returned and there was a significant toxic amount of methadone found in the SC's system indicating that the child had to be given this lethal amount of methadone. It was unknown at this time if the methadone was given in one dose or given in incremental amounts over time. The biological mother (BM) was on methadone at the time the SC was born. The subsequent report was consolidated and closed into the open SCR report.

Executive Summary

This fatality report concerns the death of a nine-month-old female that occurred on 1/18/15. The final autopsy received on 6/15/15 indicated the cause of death was undetermined and manner of death was acute methadone intoxication. MCDHS received an SCR report regarding the death of the SC.

Present in the home on the day the SC died was the BM, the SC, the MGM, a maternal aunt (MA), a female unrelated household member (UHM), a male UHM, the male UHM's daughter, and the male UHM's male friend.

Through interviews, MCDHS learned the MGM and the SC woke up and the SC had her first bottle around 5:30-6:00am and they went back to sleep. The SC woke around 8:30-9am and the MGM got the SC out of the crib. The SC was playing and crawling on the bed. The MGM said it was possible the SC was crawling on the floor but she was unsure. The SC had breakfast and then played with the male UHM's daughter. After playing for a while, the SC started acting sleepy and then fell asleep. The MGM put the SC in her crib for a nap on her side which was how she normally slept. There was nothing covering her face or obstructing her ability to breathe. The only objects in the crib were a blanket covering the SC and bumpers around the inside of the crib. The BM woke up at 11:00am when the MGM brought the SC upstairs for a nap. The SC was sleeping on her stomach with her head facing the wall. At some point, the female UHM observed the SC sleeping chest to chest with the MA; however, no one else reported this. The female UHM took a nap with the male UHM daughter. The SC sounded raspy so the BM took the SC's temperature which was a little over 100 degrees. The BM gave the SC 2.5ml of a prescription pain/fever medication that was given to her 9/14 when the SC was seen at urgent care for congestion, coughing, a fever and a runny nose. The BM put the SC on her stomach in the crib. The SC had a fleece blanket up to her lower back area. Around 4:30pm, the BM checked on the SC and found she was not breathing. The SC was warm to the touch and her lips were bluish in color. She denied that the SC was stiff. The female UHM and the male UHM's daughter were sleeping in the same room with the SC when the SC was found unresponsive. The BM brought the SC downstairs and the male UHM, who was a certified nursing assistant (CNA), began performing CPR. He said the SC's skin was pale white and that her lips were purple. He noted there was blood in her nasal mucus. He denied observing any petechial on the SC. The male UHM's male friend called 911. The female UHM woke up to the commotion and went downstairs. The male

UHM's daughter started coming downstairs so the male UHM's male friend took her away from the situation. EMS arrived and said there was vomit in the crib but the BM did not notice it when she checked on her. EMS reported the SC did have a pulse but she was not breathing. The SC was turning blue, she was limp and her eyes were dull. EMS transported the SC to the hospital where she was pronounced dead.

According to the ME, a lethal dose of methadone was found in the SC's system and may have contributed to her death. The Toxicologist at the ME's office stated the methadone was significantly metabolized in the SC's body. There was also an over the counter medication found in the SC's system that was consistent with a therapeutic amount. There were no visible signs of trauma.

MCDHS found the MGM and MA were prescribed methadone. After review with their methadone providers, the only person prescribed take a home methadone was the MGM. All denied that they did or that someone would have intentionally harmed the SC.

MCDHS conducted an adequate assessment of immediate danger to all children named in the report within 24 hours, completed adequate safety assessments, implemented appropriate safety plans when needed, appropriate collateral contacts were made, and service needs were adequately assessed and offered.

The SCR report remained open as of the date of this report.

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?** N/A
- **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?** The CPS report had not yet been determined at the time this Fatality report was issued.
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
Casework Activity was commensurate with case activities.

Was the decision to close the case appropriate? Unknown

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:
N/A

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: 01/18/2015 **Time of Death:** 05:03 PM

County where fatality incident occurred: MONROE
Was 911 or local emergency number called? Yes
Time of Call: 04:28 PM
Did EMS to 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? Yes
How long before incident was the child last seen by caretaker? 2 Hours
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was: Not impaired.

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

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Aunt/Uncle	Alleged Perpetrator	Female	35 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Female	9 Month(s)
Deceased Child's Household	Grandparent	Alleged Perpetrator	Female	68 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	35 Year(s)
Deceased Child's Household	Unrelated Home Member	Alleged Perpetrator	Male	25 Year(s)
Deceased Child's Household	Unrelated Home Member	Alleged Perpetrator	Female	51 Year(s)

Other Household 1	Father	No Role	Male	45 Year(s)
Other Household 2	Other	No Role	Female	1 Year(s)

LDSS Response

All who had knowledge denied that the SC fell or had any injury 72 hours prior to her death. The SC did not have any medical conditions but had a cough, congestion and sneezing for 1-2 weeks prior to her death. She was scheduled to see the pediatrician the day after she died.

The day the SC died, the BM was MHA'd due to making statements that there was no reason to live. During her hospital stay, A drug screen was performed on the BM and she was negative for methadone and all other drugs tested. The BM was released on 1/27/15 and went to a homeless shelter. She had an intake appointment scheduled for counseling. The BM reported that she had not been taking methadone for six months.

MCDHS observed the home which was cluttered with items all over the floor that could be hazardous to young children. There was evidence of marijuana and paraphernalia throughout the home. All reported the marijuana was the male UHM's. There was a rifle and two shot gun shells on the dresser which the MGM put away. MCDHS advised the drugs, the medications and the gun needed to be put out of reach of children. MCDHS made a safety plan with the male UHM and his child's mother that the male UHM's daughter would not return to that home until the home was clean and safe. The home was cleaned by the UHM's and MCDHS agreed the safety plan could be lifted.

After the SC's death, the MGM moved out of the home and the MA was not allowed back in the home after the UHM's found syringes, pills and drug paraphernalia in her room.

The two UHM's denied they used methadone. The male UHM admitted to using marijuana but denied using in the presence of his daughter or having marijuana accessible to her when she was visiting the home.

The MGM reported that she had MH issues and took multiple medications; including methadone in a pill form. When MCDHS asked for the MGM medications, she did not know where they were but later found them in an area that was accessible to toddlers which MCDHS addressed. According to the MGM's physician, the MGM was prescribed methadone, as well as other medications, due to a medical condition and not due to a history of heroin or other drug use. The MGM's physician denied concerns that she was misusing her medications.

After the SC died, the MA was placed in an inpatient substance abuse facility due to cocaine use and she was on methadone. The MA had to pick up the liquid methadone daily because she was testing positive and not allowed to take it home. This methadone program verified that the MA was unable to take methadone home for over a year.

The female UHM's physician did not have any concerns about the female UHM or that she was misusing her medication.

A provider working with the MGM reported that during a visit with the MGM, she observed a pill on the floor and gave it to the MGM. It appeared to be an over the counter pain medication. Other collateral contacts for the family and the UHM's reported no concerns.

LE and MCDHS shared with the MGM the preliminary autopsy results that the SC passed away from a lethal dose of Methadone. The MGM was upset and stated she did not want to believe it. The MGM did have pills in her purse and one time found loose pills in her purse. The MA and MGM reported that it was possible the SC got into something accidentally

like someone dropping medicine. However, no one recalled dropping any medication.

The subject child was born with methadone in her system since the BM was taking the medication as prescribed. The Toxicologist reported that the methadone would not still be in her system from her birth.

MCDHS offered preventive services to the BM which she declined.

Official Manner and Cause of Death

Official Manner: Undetermined
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 reviewed by an OCFS approved Child Fatality Review Team?Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
017727 - Deceased Child, Female, 9 Mons	017728 - Mother, Female, 35 Year(s)	DOA / Fatality	Pending
017727 - Deceased Child, Female, 9 Mons	017733 - Aunt/Uncle, Female, 35 Year(s)	Poisoning / Noxious Substances	Pending
017727 - Deceased Child, Female, 9 Mons	017733 - Aunt/Uncle, Female, 35 Year(s)	Inadequate Guardianship	Pending
017727 - Deceased Child, Female, 9 Mons	017733 - Aunt/Uncle, Female, 35 Year(s)	DOA / Fatality	Pending
017727 - Deceased Child, Female, 9 Mons	017732 - Unrelated Home Member, Female, 51 Year(s)	Poisoning / Noxious Substances	Pending
017727 - Deceased Child, Female, 9 Mons	017732 - Unrelated Home Member, Female, 51 Year(s)	Inadequate Guardianship	Pending
017727 - Deceased Child, Female, 9 Mons	017732 - Unrelated Home Member, Female, 51 Year(s)	DOA / Fatality	Pending
017727 - Deceased Child, Female, 9 Mons	017728 - Mother, Female, 35 Year(s)	Lack of Supervision	Pending
017727 - Deceased Child, Female, 9 Mons	017731 - Unrelated Home Member, Male, 25 Year(s)	Poisoning / Noxious Substances	Pending
017727 - Deceased Child, Female, 9 Mons	017731 - Unrelated Home Member, Male, 25 Year(s)	DOA / Fatality	Pending

017727 - Deceased Child, Female, 9 Mons	017729 - Grandparent, Female, 68 Year(s)	Poisoning / Noxious Substances	Pending
017727 - Deceased Child, Female, 9 Mons	017729 - Grandparent, Female, 68 Year(s)	Inadequate Guardianship	Pending
017727 - Deceased Child, Female, 9 Mons	017729 - Grandparent, Female, 68 Year(s)	DOA / Fatality	Pending
017727 - Deceased Child, Female, 9 Mons	017728 - Mother, Female, 35 Year(s)	Poisoning / Noxious Substances	Pending
017727 - Deceased Child, Female, 9 Mons	017728 - Mother, Female, 35 Year(s)	Inadequate Guardianship	Pending
017727 - Deceased Child, Female, 9 Mons	017731 - Unrelated Home Member, Male, 25 Year(s)	Inadequate Guardianship	Pending
017727 - Deceased Child, Female, 9 Mons	017729 - Grandparent, Female, 68 Year(s)	Lack of Supervision	Pending

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:

MCDHS made diligent efforts to locate the biological father (BF) to no avail.

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	☒	☐	☐	☐

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 and placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving siblings/other children in the household removed as a result of this fatality report/investigation?	☐	☒	☐	☐

Legal Activity Related to the Fatality

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

Have any Orders of Protection been issued? No

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Needed but not Offered	Needed but Unavaliable	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 mother sought MH services and housing assistance on her own. She declined bereavement services.

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?	N/A
Was the child acutely ill during the two weeks before death?	Yes

Infants Under One Year Old

During pregnancy, mother:

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

Infant was born:

- ☒ Drug exposed
- ☐ With neither of the issues listed noted in case record
- ☐ With fetal alcohol effects or syndrome

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)
06/04/2014	3193 - Deceased Child, Female, 9 Months	3194 - Father, Male, 45 Years	Inadequate Guardianship	Indicated	Yes

Report Summary:
The report alleged that the BF was physically assaulting the BM in the presence of the SC. The BF was very controlling and threatening and the BM was very frightened of him.

Determination: Indicated | **Date of Determination:** 08/18/2014

Basis for Determination:
The BM admitted the BF was violent and threatened to kill her when the SC was in the home. The BF denied that was true. The BM said the BF grabbed the SC from her arms to get her to return home. The BM obtained temporary custody of the SC and a stay away OOP against the BF. MCDHS deemed the BF failed to provide a minimum degree of care and placed the SC at risk of harm. As a result, MCDHS found some credible evidence the BF was physically abusive and intimidating and SUB the allegations.

MCDHS referred the BM to attend a DV program and encouraged her to reengage with mental health counseling. The BM was engaged and following through with methadone treatment. MCDHS discussed safe sleep.

OCFS Review Results:
MCDHS conducted an adequate assessment of immediate danger to the child named in the report within 24 hours,

completed adequate safety and risk assessments, implemented appropriate safety plans when needed, made appropriate collateral contacts, and gathered sufficient information and appropriately determined each allegation of abuse and maltreatment.

Service needs were adequately assessed and services were offered to the BM only. Service needs were identified for the BF; however, there was no documentation that the BF was offered DV services.

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

Issue:
Failure to Offer Services

Summary:
There was no documentation that services were offered to the BF after there was an identified service need of DV services.

Legal Reference:
SSL 424(10); NYCRR 428.6

Action:
A corrective action plan must be developed by MCDHS which supports offering appropriate services.

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

The BM was listed with no role in two UNF SCR reports. The first was dated 3/19/06 with allegations of CDRG and PDAM against the BM's then paramour regarding his child. The second was dated 3/6/08 with allegations of IG and PDAM against the MGM regarding a minor female and male maternal cousins. There were further allegations of CDRG against the MGM regarding the minor maternal cousin.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Services Open at the Time of the Fatality

Required Action(s)

Are there Required Actions related to compliance issues for provisions of CPS or Preventive services ?
☐Yes ☒No

Preventive Services History

There is no record of Preventive Services History provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

Required Action(s)

Are there Required Actions related to the compliance issues for provision of Foster Care Services?
☐Yes ☒No

Foster Care Placement History

There is no record of foster care placement history provided to the deceased child, the deceased child's siblings, and/or the other children residing in the deceased child's household at the time of the fatality.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation?
☐Family Court ☐Criminal Court ☒Order of Protection

Have any Orders of Protection been issued? Yes	
From: 08/14/2015	**To:** 08/26/2014

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