Office of Children and Family Services

Child Fatality Report

Report Identification Number: NY-17-138

Prepared by: New York City Regional Office

Issue Date: Jun 06, 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: 20 day(s)
Jurisdiction: Bronx
Gender: Female
Date of Death: 12/12/2017
Initial Date OCFS Notified: 12/12/2017

Presenting Information

On 12/12/17, the SCR registered two reports concerning the death of the SC. The reports alleged the mother fell asleep at an unknown time, while feeding the 20-day-old SC. The report alleged when the mother woke up, the SC was unresponsive and had blood over her mouth. The mother called 911 and the SC was transported to Jacobi Hospital where she was pronounced dead at 5:10 A.M. The report alleged the SC's cause of death was due to asphyxiation and cardiac arrest. There were no marks or bruises on the SC's body. The SC had no pre-existing condition that could have contributed to her death.

Executive Summary

The female SC was 20 days old when she died on 12/12/17. As of 4/23/18, the ME has not issued the autopsy report or provided a verbal cause and manner of death.

On 12/12/17, the SCR registered two reports concerning the death of the SC. The allegations of the report were DOA/FATL, II, L/S and IG of the SC; and L/S and IG of the sibling by the mother.

The mother was 18-years-old and resided with her children in the home of the MGP's. They shared a two-bedroom apartment in a New York City Housing Authority (NYCHA) building. There were also two MAs ages: 8 and 19 years old in the home.

On 12/12/17, ACS initiated the investigation within the required time frame by conducting a home visit. ACS had safety concerns about the condition of the home; which was described as dim, dirty, cluttered, and infested with roaches. ACS also found the 2-year-old sibling was sharing a full-size bed with the 8-year-old MA. ACS observed there was an adequate amount of food and provisions for the children in the home. ACS addressed these concerns with the family and the matter was rectified by 12/13/17. The family cleaned the home and purchased a toddler bed for the sibling.

According to the mother, on 12/11/17 she visited the MGGM's home with the children and arrived at the case address at 11:00 P.M. The mother and the SC took a nap. The documentation did not specify where the SC was placed to sleep for the nap. The two woke up at about 1:30 A.M. The mother then began to feed the SC. The mother was sitting on the couch, cradling and feeding the SC. The mother said she fell asleep, woke up at about 5:00 A.M., found herself lying on top of the SC who was unresponsive, and then alerted the MGPs who called 911 and administered CPR as instructed by the operator. EMS arrived at the home and transported the SC to Jacobi Hospital where the SC was pronounced dead. The MGPs corroborated the mother's account.

The NYPD found no criminality surrounding the SC's death. Neither the ME nor the medical staff found any signs of abuse or maltreatment.

ACS held a Child Safety Conference (CSC) and determined court intervention was necessary. The documentation did not clearly state why ACS determined court intervention was necessary within the 24-hour time frame when there were no documented safety concerns for the surviving sibling.

On 12/13/17, ACS filed an Article 10 Neglect Petition at the Bronx Family Court (BxFC) on behalf of the sibling naming the mother as the respondent. ACS was granted court ordered supervision (COS). ACS did not consider the information

gathered when making decisions to take court action against the mother or when completing the risk and safety assessments.

ACS contacted the father via telephone at the correctional facility and he had no concerns about the mother's ability to care for the children. ACS interviewed several paternal and maternal family members and none had concerns for the children's safety.

On 1/22/18, ACS conducted the required joint home visit with the New York Foundling (NYF) PPRS CW and the mother signed the application for services.

On 2/9/18, ACS indicated the report and substantiated the allegations against the mother concerning the SC. However, no narrative was documented for the allegations of DOA/FATL, II or L/S. In addition, the information documented in the investigation did not support the substantiation of these allegations. ACS unsubstantiated the allegations of IG and L/S of the sibling by the mother. However, ACS did not provide narratives to support this determination.

ACS provided a narrative to support the substantiation of the IG of the SC and the sibling by the mother. ACS cited the mother failed to provide adequate shelter and provisions for the two children. ACS specified the mother had a crib, but did not use it for the SC. Concerning the 2-year-old sibling, ACS documented she did not have an adequate sibling arrangement as she was bed-sharing with the 8-year-old MA.

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?** Unable to Determine
- **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?** Unable to determine - insufficient documentation.
- **Was the determination made by the district to unfound or indicate appropriate?** Unable to Determine

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:
The assessments in this case did not reflect the decisions taken were based on the case circumstances. ACS did not use the information gathered to properly conduct a thorough investigation.

Required Actions Related to the Fatality

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

Issue:	Appropriateness of allegation determination
Summary:	ACS did not provide supportive narratives for the determination of the allegations of DOA/FATL, II or LS of the SC or unsubstantiation of LS and IG of the sibling.
Legal Reference:	FCA 1012 (e) & (f);18 NYCRR 432.2(b)(3)(iv)
Action:	ACS must submit a performance improvement plan within 45 days that identifies what action it has, or will take, to address the citation(s) identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who will attend and what was discussed.
Issue:	Timely/Adequate 24 Hour Assessment
Summary:	The safety decision reflected that safety factors did not rise to the level of immediate and impending danger of serious harm. However, there were no safety factors present at this time. Yet, ACS filed a neglect petition against the mother.
Legal Reference:	SSL 424(6);18 NYCRR 432.2(b)(3)(i)
Action:	ACS must submit a performance improvement plan within 45 days that identifies what action it has, or will take, to address the citation(s) identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who will attend and what was discussed.
Issue:	Timely/Adequate Seven Day Assessment
Summary:	The safety decision reflected that safety factors did not rise to the level of immediate and impending danger of serious harm. However, there were no safety factors present at this time.
Legal Reference:	SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)
Action:	ACS must submit a performance improvement plan within 45 days that identifies what action it has, or will take, to address the citation(s) identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who will attend and what was discussed.
Issue:	Adequacy of Risk Assessment Profile (RAP)
Summary:	ACS failed to add a secondary caretaker. The mother and her children were mostly supported by the MGPs; the MGM assisted with the care of the children.
Legal Reference:	18 NYCRR 432.2(d)
Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Assessment as to need for Family Court Action
Summary:	ACS filed a neglect petition based on the family's history of generational co-sleeping. The Family Court recommended bereavement counseling and COS.
Legal Reference:	SSL 424.11; 18 NYCRR 432.2(b)(3)(vi)

Action:	ACS must meet with the staff involved in this fatality investigation, inform NYCRO of the date of the meeting, who attended, what was discussed; and submit a Performance Improvement Plan within 45 days that identifies what action it has taken or will take to address this issue.
Issue:	Timely/Adequate 30-Day Safety Assessment
Summary:	Safety assessments were not completed properly; there did not appear to be an understanding of safety and risk. The 30 day safety decision noted there was immediate and impending danger of serious harm, this was not supported by case documentation.
Legal Reference:	CPS Program Manual, Chapter 6, K-2
Action:	ACS must submit a performance improvement plan within 45 days that identifies what action it has, or will take, to address the citation(s) identified in the fatality report. ACS must meet with the staff involved with this fatality investigation and inform NYCRO of the date of the meeting, who will attend and what was discussed.

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 12/12/2017 **Time of Death:** 05:10 AM

County where fatality incident occurred: Bronx
Was 911 or local emergency number called? Yes
Time of Call: 04:20 AM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? N/A
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
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
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Aunt/Uncle	No Role	Female	19 Year(s)
Deceased Child's Household	Aunt/Uncle	No Role	Female	8 Year(s)

Deceased Child's Household	Deceased Child	Alleged Victim	Female	20 Day(s)
Deceased Child's Household	Grandparent	No Role	Male	38 Year(s)
Deceased Child's Household	Grandparent	No Role	Female	37 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	18 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	2 Year(s)
Other Household 1	Father	No Role	Male	21 Year(s)

LDSS Response

On 12/12/17, ACS initiated the investigation timely and made contact with the NYPD, medical staff at the ER, and the ME concerning the circumstances surrounding the SC's death.

According to the EMS report, the 911 call was received at 4:20 A.M and EMS arrived at the case address 4:40 A.M. The SC was transported to Jacobi Hospital where she arrived at 4:44 A.M. Efforts to resuscitate the SC by EMS and the medical staff failed and she was pronounced dead at 5:10 AM.

The medical staff at Jacobi Hospital stated the mother reported she fell asleep while feeding the SC a bottle of formula. The mother did not know at what point she fell asleep, but when she awoke, she was "slumped over" the SC. The mother told ACS the SC was unresponsive with blood coming out of her mouth. There were no concerns of alcohol or drug use by the mother.

On 12/12/17, ACS made an initial home visit to the case address and found it was unkempt and there were roaches crawling on the walls. ACS had concerns about the safety of the sibling; therefore, the family agreed to leave the sibling at a relative's home while they cleaned and organized the home.

ACS observed the family shared a small two-bedroom apartment. Therefore, the mother slept on the couch located in the living room with the SC who had a bouncer where she was usually placed to sleep. The 2-year-old sibling shared a bedroom with her MAs. There was a bunk bed with a trundle. The sibling slept on the bottom full size bed with the eight-year-old MA and the 19-year-old MA slept on the trundle. No one slept on the top bed because the space was too hot. ACS determined the co- sleeping between the children presented a safety factor.

ACS documented the safety concerns did not rise to the level of immediate and impending danger of serious harm; however, they filed an Article 10 Neglect Petition against the mother. ACS determined court intervention was required because they discovered there was a history of generational co-sleeping throughout the maternal family. However, the mother had purchased a toddler bed for the sibling prior to ACS seeking court intervention. The issue concerning the "generational co-sleeping" in the other household involving family members should not have been a cause to seek court intervention. Despite this fact, the Family Court granted ACS COS.

The Family Court judge recommended bereavement services and parenting skills training for the mother. Prior to ACS court intervention, the mother accepted the services recommended by ACS. ACS referred the mother for PPRS and a service case was opened for supervision.

The NYPD and medical staff noted the SC's death was due to asphyxiation, but this was not confirmed by the ME. ACS made a final contact with the ME on 1/31/18, and no preliminary cause or manner of death was discussed as test results were pending. However, the ME noted there was no indication the "cause" of death was intentional.

Collateral contacts with the children's pediatrician revealed there were no concerns about the children's medical care.

On 2/9/18, ACS indicated 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)?No
Comments: This investigation adhered to previously approved protocols for joint investigation.

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No
Comments: There is no OCFS approved Child Fatality Review Team in the NYC region.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
045294 - Sibling, Female, 2 Year(s)	045290 - Mother, Female, 18 Year(s)	Inadequate Guardianship	Unsubstantiated
045294 - Sibling, Female, 2 Year(s)	045290 - Mother, Female, 18 Year(s)	Lack of Supervision	Unsubstantiated
045785 - Deceased Child, Female, 20 Day(s)	045290 - Mother, Female, 18 Year(s)	Internal Injuries	Substantiated
045785 - Deceased Child, Female, 20 Day(s)	045290 - Mother, Female, 18 Year(s)	Inadequate Guardianship	Substantiated
045785 - Deceased Child, Female, 20 Day(s)	045290 - Mother, Female, 18 Year(s)	DOA / Fatality	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?	☒	☐	☐	☐
Did the investigation adhere to established protocols for a joint investigation?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
N/A

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?	☐	☐	☒	☐

Explain:
The safety assessments were not completed properly; there did not appear to be a clear understanding of safety and risk. The 30 day safety decision documented there was immediate and impending danger of serious harm, but this was not supported by the selected safety factors or case documentation.

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 RAP was not completed properly as it did not list a secondary caretaker. The MGM assisted the mother with the care of the children and the MGP's provider shelter for the mother and the children. The SC did not die due to abuse or maltreatment.

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?	☐	☒	☐	☐

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation?
☒Family Court ☐Criminal Court ☐Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
12/13/2017	There was not a fact finding	There was not a disposition
Respondent:	045290 Mother Female 18 Year(s)	
Comments:	ACS was granted COS for twelve months; no less than six months. The fact finding was scheduled for 6/5/18.	

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? N/A
Explain:
There were no immediate services needed for the siblings. However, the sibling was subsequently referred for early intervention services.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
There were no immediate need of services in response to the fatality. However, the family was later referred for PPRS and bereavement services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment? No
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? No
Was the child acutely ill during the two weeks before death? No

Infants Under One Year Old

During pregnancy, mother:

☐ Had medical complications / infections
☐ Misused over-the-counter or prescription drugs
☐ Experienced domestic violence
☒ 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

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 history more than three years prior to the fatality.

Known CPS History Outside of NYS

The family had no known CPS history outside NYS.

Legal History Within Three Years Prior to the Fatality

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

Recommended Action(s)

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

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