Child Fatality Report

Report Identification Number: SY-18-043

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

Issue Date: Mar 11, 2019

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: 1 month(s)
Jurisdiction: Onondaga
Gender: Male
Date of Death: 10/04/2018
Initial Date OCFS Notified: 10/04/2018

Presenting Information

An SCR report alleged the subject mother slept in the same bed with the 8-week-old subject child. On 10/4/2018, the mother got up at about 6:30 AM and realized the infant was bleeding from his nose and his body was cold. The mother immediately called 911. The police and ambulance responded at 6:23 AM and the baby was taken to the hospital. The baby was pronounced dead at 7:07 AM, and had been otherwise healthy.

Executive Summary

On 10/4/2018, Onondaga County Department of Children and Family Services (OCDCFS) received an SCR report concerning the death of an 8-week-old male child, who died while sharing a bed with his mother and sibling. All adults in the home were named alleged subjects – the SM, her sister, and her two uncles.

The SM reported the SC fell asleep following a feeding in SM's full-sized adult bed around 11:30 PM the night prior to the incident. His 2-year-old brother was also asleep in this bed. The SM got into bed between the children, which she reported was how they slept every night. The SC was placed on his back. The SM went to sleep, and awoke between 6:00 and 6:20 AM to find the SC unresponsive and cold, with blood coming from his nose. She stated he was found on his back. The SM screamed for help and attempted to administer CPR. The SM's uncle who resided in the home called 911, and EMS responded within minutes of the call. Life-saving efforts were made while the child was transported to the hospital, and CPR continued upon arrival. The child could not be revived, and the SM requested doctors cease resuscitation efforts. The SC was pronounced deceased at 7:07 AM.

The ME was contacted on the date of the fatality, and it was reported the child had lividity around his mouth, nose, and abdomen. The ME noted this was consistent with the prone position, and inconsistent with the mother's account of the child's position while sleeping and when found. On 10/30/18, a copy of the ME's autopsy report was received. The cause of death was noted as "sudden death associated with unsafe sleep environment," and the manner of death was "undetermined." Though petechial hemorrhages were found on the surface of the heart, the ME explained they might have suggested asphyxia as a cause of death; however, it was noted CPR could have also caused them. When other factors were considered, there was nothing else identified that appeared to have caused or contributed to the death.

OCDCFS conducted a joint investigation with law enforcement. There was no indication any criminal charges were filed regarding the fatality. LE accompanied OCDCFS to investigate a subsequent SCR report made on 12/10/18, alleging injuries to the 2-year-old SS; however, OCDCFS found the marks to be consistent with that of an active toddler. OCDCFS made appropriate referrals for the family when needs were identified. OCDCFS suggested grief counseling, preventive services, parenting classes, and a dental appointment for the SS for a concern about his tooth. The SM made a dentist appointment, but refused other services that were offered. The SM continued to engage with Onondaga's county-run Healthy Families program, with whom she was involved prior to the birth of the SC. She was considering grief counseling services at the time this report was written. Financial assistance was provided for funeral and burial costs.

The safety of the one SS in the home was adequately assessed and documented at pertinent points throughout the investigation. Though occasional safety concerns arose, they were mitigated with the assistance of OCDCFS. Efforts were made to assess the safety of the BF's two other children, who resided with their mothers. Contact was only able to be made with one of them. Neither of those siblings visited the household on a regular basis or around the time of the SC's life. It was documented there were no safety concerns for any of the surviving siblings as it pertained to the fatality, given

the absence of risk factors for unsafe sleep injuries since the children were ages 2, 4 and 10.

Based on the information gathered, OCDCFS substantiated the allegations against the mother. OCDCFS concluded there was no credible evidence to substantiate allegations against the other adult household members, given the mother was responsible for the sleeping provisions. The CPS investigation was then closed.

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:
Decisions were well-documented and actions taken were appropriate.

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:
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: 10/04/2018 **Time of Death:** 07:07 AM

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

County where fatality incident occurred: Onondaga
Was 911 or local emergency number called? Yes
Time of Call: 06:21 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
How long before incident was the child last seen by caretaker? 7 Hours
At time of incident supervisor was:

- ☐ Drug Impaired
- ☐ Alcohol Impaired
- ☐ Distracted
- ☐ Impaired by disability
- ☐ Absent
- ☒ Asleep
- ☐ Impaired by illness
- ☐ 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	Aunt/Uncle	Alleged Perpetrator	Male	51 Year(s)
Deceased Child's Household	Aunt/Uncle	Alleged Perpetrator	Male	54 Year(s)
Deceased Child's Household	Aunt/Uncle	Alleged Perpetrator	Female	27 Year(s)
Deceased Child's Household	Deceased Child	Alleged Victim	Male	1 Month(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	24 Year(s)
Deceased Child's Household	Sibling	No Role	Male	2 Year(s)
Other Household 1	Father	No Role	Male	30 Year(s)
Other Household 2	Other Adult - SS's Biological Father	No Role	Male	27 Year(s)

LDSS Response

Upon receiving the SCR report regarding the fatality, OCDCFS coordinated a home visit with LE to observe where the fatal incident took place. OCDCFS interviewed a MU, the only household member at the scene at the time, and coordinated interviews with other family members. OCDCFS promptly reviewed CPS history and made the proper notifications. OCDCFS obtained pertinent information from collateral contacts such as hospital staff, police, and the

pediatrician.

OCDCFS learned the last time SM saw SC awake and alert was at 11:30 PM the night prior to the fatality. The SM reported to OCDCFS she fed and burped the child before taking both children upstairs to sleep in her bed. Once SC was asleep, SM got into bed between the children; she noted these were their typical sleeping arrangements. She awoke between 6:00 and 6:20 AM and saw the SC had blood coming from one nostril and mucus in the other. She noted he was cold, and ran out of the room with him to try to get help. She screamed for someone in the home to call 911, which the eldest maternal great uncle did. SM ran out of the house screaming for help and began doing chest compressions on the SC. EMS arrived, administered oxygen, and transported SC to the hospital. SM said when she arrived at the hospital, CPR was still being performed. She requested that they stop and allow the child to "go in peace," after having been given medical advice about his condition. Shortly thereafter, the child was pronounced deceased. The SM denied she was under the influence of drugs or alcohol; she denied the use of any drugs.

OCDCFS documented an assessment of the 2-year-old SS's safety throughout the case. There were no safety concerns regarding the fatality, as the same risk concerning safe sleep was not applicable given his age. When safety concerns arose, such as accessibility to an open window where the SS slept and a subsequent CPS report being made 2 months later, OCDCFS promptly addressed the concerns and helped create plans with the family to protect the child.

The BF was incarcerated at the time of the SC's birth and death. OCDCFS documented hospital staff offered bereavement support to the family and contacted the BF to notify him of his son's death. OCDCFS coordinated with Seneca County DSS to conduct a face-to-face interview with the BF in jail. He was released prior to the interview, and OCDCFS spoke with the BF in the home about the allegations and other areas of potential child welfare concern.

OCDCFS documented BF had 2 other children by different women, and noted the infrequency of their contact with the subject family. OCDCFS visited BF's 10-year-old daughter in her home, and spoke with her mother. It was learned she had not seen her father since before he was incarcerated in May of 2018, and saw him sparsely prior to that. OCDCFS made efforts to see BF's 4-year-old son face-to-face, but attempts were unsuccessful.

The CW thoroughly discussed safe sleep with the SM. The SM reported she had been counseled on safe sleep, though she had shared a bed with her eldest son and she continued the same practices with the SC. Prior to the fatality, the pediatrician and Healthy Families worker encouraged safe sleep on numerous occasions, to whom SM voiced her decision to continue to share a bed with her children. She had been provided a portable crib and had an additional crib; however, neither were assembled.

The SC was last seen at the pediatrician on 10/3/18 for a well child exam, where no medical concerns were noted. The SM had reported SC had mild sneezing and coughing the day prior.

The SM expressed a need for therapy given her grief. The CW discussed this at length and provided information. The CW also provided SM with books to help the SS understand loss and grieving. The CW offered preventive services and parenting classes, though services were declined.

Official Manner and Cause of Death

Official Manner: Undetermined
Primary Cause of Death: Undetermined if injury or medical 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
Comments: The fatality was scheduled for review by the Onondaga Child Fatality Review Team for February, 2019.

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
049149 - Deceased Child, Male, 1 Month(s)	049142 - Aunt/Uncle, Male, 51 Year(s)	DOA / Fatality	Unsubstantiated
049149 - Deceased Child, Male, 1 Month(s)	049143 - Aunt/Uncle, Female, 27 Year(s)	Inadequate Guardianship	Unsubstantiated
049149 - Deceased Child, Male, 1 Month(s)	049144 - Mother, Female, 24 Year(s)	Inadequate Guardianship	Substantiated
049149 - Deceased Child, Male, 1 Month(s)	049142 - Aunt/Uncle, Male, 51 Year(s)	Inadequate Guardianship	Unsubstantiated
049149 - Deceased Child, Male, 1 Month(s)	049143 - Aunt/Uncle, Female, 27 Year(s)	DOA / Fatality	Unsubstantiated
049149 - Deceased Child, Male, 1 Month(s)	049144 - Mother, Female, 24 Year(s)	DOA / Fatality	Substantiated
049149 - Deceased Child, Male, 1 Month(s)	049141 - Aunt/Uncle, Male, 54 Year(s)	Inadequate Guardianship	Unsubstantiated
049149 - Deceased Child, Male, 1 Month(s)	049141 - Aunt/Uncle, Male, 54 Year(s)	DOA / Fatality	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 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:
Financial assistance was provided for funeral costs, as the mother was on a fixed income. A referral was made for counseling which the mother was in process of setting up. Other preventive services were offered, but were declined. The mother and her son continued to utilize the services of Healthy Families.

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: No children needed to be 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	☒	☐	☐	☐	☐	☐	☐
Other, specify: Healthy Families							

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:
OCDCFS provided the mother with books containing information on how to talk to children about grief and loss.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:
The mother was provided monetary assistance for funeral and burial costs. She was referred to grief counselors and was in process of setting up an appointment.

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

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
05/08/2018	Sibling, Male, 3 Years	Mother, Female, 24 Years	Lack of Supervision	Unsubstantiated	No
	Sibling, Male, 3 Years	Mother, Female, 24 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Sibling, Male, 1 Years	Mother, Female, 24 Years	Lack of Supervision	Unsubstantiated	
	Sibling, Male, 1 Years	Mother, Female, 24 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	

Sibling, Male, 3 Years	Mother, Female, 24 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 1 Years	Mother, Female, 24 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 3 Years	Father, Male, 30 Years	Inadequate Guardianship	Unsubstantiated
Sibling, Male, 1 Years	Father, Male, 30 Years	Inadequate Guardianship	Unsubstantiated

Report Summary:
An SCR report alleged on 5/5/18, the police raided the home while two surviving siblings were present - SM's child (age 2) and BF's child (age 3). The BF was arrested for selling heroin and crack from the home, and the SM was aware but did not intervene. Since the raid, the SM continued to sell the drugs from the home while the children were present. The SM also allegedly smoked marijuana, and when she did so, she would fall asleep leaving the children unsupervised. The role of BF's son's mother was unknown.

Report Determination: Unfounded | **Date of Determination:** 07/11/2018

Basis for Determination:
OCDCFS learned the BF was arrested and incarcerated for drug related charges after a police search of the home; however, the children were not present at the time and were residing elsewhere with the SM. There was no evidence of substance or alcohol use in the home, and the SM denied any part of what was alleged. Both parents denied substances were used or sold from either home; BF believed he was framed. OCDCFS concluded the children were not impacted by the events leading to the BF's arrest, as they were not residing in that home.

OCFS Review Results:
OCDCFS conducted a thorough investigation into the allegations and inquired of all relevant parties information about other areas of potential child welfare concern. OCDCFS provided the SM with information for services, though she stated was not interested. OCDCFS completed a court-ordered investigation, which was documented as a "services" case type, which was open from 7/6/18-7/13/18. The matter concerned custody, given BF's incarceration. When necessary, OCDCFS made service referrals for the SS's mother. Though the SM's pregnancy was discussed with both parents, recommended safe sleep practices were not discussed, despite the opportunity to educate the family.

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

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

7/25/2005-10/27/2005 The 54-year-old maternal great uncle was a confirmed subject in a report alleging inadequate guardianship of his son and his son's mother's child.

Known CPS History Outside of NYS

There was no known CPS 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