CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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CONTENTS

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A child fatality or near-fatality review completed pursuant to RCW 43.216.650 is subject to discovery in a civil or administrative proceeding, but may not be admitted into evidence or otherwise used in a civil or administrative proceeding except pursuant to RCW 43.216.650(4a).

Given its limited purpose, a child fatality review or child near-fatality review (CFR/CNFR) should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. The CFR/CNFR committee's review is generally limited to documents in the possession of or obtained by DCYF or its contracted service providers. The committee has no subpoena power or authority to compel attendance. A CFR/CNFR is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's fatal injury. Nor is it the function or purpose of a CFR/CNFR to recommend personnel action against DCYF employees or other individuals. Information discovered through the review may be used in DCYF disciplinary actions such as revocation or suspension of a child care license.

Full Report

Child

- I.J.

Date of Child's Birth

- RCW 74.13.515, 2018

Date of Fatality

- August 17, 2021

Child Fatality Review Dates

- December 13 and 14, 2021

Committee Members

- Travis Hansen, Senior Child Care Administrator, DCYF
- Liz Montgomery, Executive Director, Northwest Infant Survival & SIDS Alliance
- Karin Anderson, Senior Manager of Early Learning, Child Care Aware
- Bridget Grosso, Senior Detective, King County Sheriff's Office
- Bat-Sheva Stein, Public Health Nurse Consultant, Washington State Department of Health
- RCW 13.50.100, Parent representative

Facilitators

- Aliza Yair, Child Care Licensing Quality Assurance and Improvement Program Manager, DCYF
- Deanna Sundby, Licensing Division Communications and Outreach Analyst, DCYF

Executive Summary

On December 13 and 14, 2021, the Department of Children, Youth, and Families (DCYF/Department) convened a Fatality Review Committee (FRC/committee) to assess the Department's actions and circumstances surrounding the death of I.J., RCW 74.13.515 old. The incident initiating the FRC occurred on August 17, 2021, when I.J. died in a licensed family home child care. The King County Medical Examiner completed an autopsy citing no concerns for abuse or neglect, and no anatomical or toxicologic cause of death. The child's death is considered a sudden, unexplained child death.

The FRC members included a public health nurse, a law enforcement officer, an advocate with expertise in sudden unexplained child deaths, a parent who previously experienced the death of her child in child care, an expert in child care programs from outside the department, and a DCYF leadership staff person. No committee member had previous contact or involvement with the family. The mother of I.J. was invited to testify to the FRC in person, by phone, or in writing. I.J.'s parent did not respond to the invitation.

For the review, each committee member received a packet of information that included the following: DCYF Licensing Division - Child Protective Services investigative assessment and case notes regarding this fatality; DCYF Child Care Licensing facility complaint report and case notes regarding this child fatality; DCYF Child Care Licensing monitoring reports from the past 5 years; and the King County Medical Examiner's Autopsy Report. All documents were un-redacted. Supplemental sources of information and resource material regarding DCYF policies, procedures, and regulations were available at the time of the review.

This report includes a summary of the case, FRC discussion, and recommendations.

Case Overview

On August 17, 2021, I.J. (RCW 74.13.515 old) died in a pack-and-play at a family home child care program, the United Home Daycare in Kent, WA, where she had been enrolled since she was four months old. The child's mother RCW 13.50.100 brought her daughter RCW 13.50.100 that day at around noon. The child is reported to have been asleep in the car prior to arriving and may have been feeling lethargic, but other reports say I.J. appeared normal and walked herself into the child care program. The child was soon placed into the pack-and-play with a bottle, and there are conflicting verbal reports whether the mother or the other staff member placed the child in the pack-and-play. The licensee of the family home child care program was in the office. The mother also went into the office and was in and out of the office and child care program space throughout the afternoon, but mostly leaving the child under the supervision of the other staff member, along with five other children. I.J. is reported to have fallen asleep at around 2:00PM and reports are conflicting whether there was a stuffed animal or pillow in the pack-and-play with I.J. The staff member may have been sleeping on the couch during the children's naptime. The staff member reported that while the other children started waking up at 3:00PM, I.J. remained asleep. At around 3:30 pm the licensee and staff member were with the other children eating snacks when the mother went to wake I.J., noticed she was blue, picked I.J. up and alerted the licensee and staff member. The licensee began CPR, while the other staff member called 911. The mother then took over performing CPR while the licensee spoke with 911, and the

other staff member took the other children outside. Paramedics arrived but were not able to resuscitate the child and pronounced her dead at the scene.

Police interviewed the mother and witnesses on scene and were suspicious of possible overdose as the cause of death. King County Medical Examiner's Office performed an autopsy with no initial findings on the cause of death. The Medical Examiner called the Intake Line, and a case was opened with Licensing Division Child Protective Services (LD/CPS). LD/CPS investigates allegations of child abuse and neglect in state licensed child care, foster care, group home and congregate facilities. A critical incident report was also opened with Child Care Licensing, which is responsible for monitoring providers' compliance with licensing regulations.

On September 30, 2021, the Kent detective spoke with the LD/CPS investigator, and he confirmed that he was told by the Medical Examiner that I.J. did not suffocate, did not have a seizure, and that there were no signs of abuse or neglect. The detective stated that he would leave the case open until the toxicology results were back.

The Medical Examiner's Toxicology report was completed on October 14, 2021, and the final autopsy report stated that there was no anatomic or toxicologic cause of death. Case notes record that the child's death was being reported as "unexplained child death."

The LD/CPS investigator conducted interviews with the mother, licensee, and the other staff member. Based on the information gathered throughout the investigation, LD/CPS determined that the allegations of negligent treatment/maltreatment of I.J. by the mother and other staff member were unfounded. There was no evidence to indicate that there was an act or a failure to act on the part of a child's parent, legal custodian, guardian, or caregiver, which showed a serious disregard of the consequences to the child of such magnitude that it created a clear and present danger to the child's health, welfare or safety. The LD/CPS investigation was closed on October 25, 2021.

DCYF Child Care Licensing received notice from the provider on August 18, 2021 regarding I.J.'s death, and a complaint case was opened. The provider voluntarily closed at that time, awaiting the results of the toxicology report and the investigations underway by law enforcement and LD/CPS. The child care licensing complaint inspection process began in October 2021, and the Child Care Licensor and Area Administrator supported the licensee in re-opening on October 11, 2021 with new staff.

The child care licensing complaint inspection included interviews, a review of staff and child records, and review of the sleep equipment used. The complaint inspection was completed on November 4, 2021, and there were valid findings regarding the following WAC:

WAC SUBCATEGORY	DETAILS
110-300-0290(6)	RCW 74.13.515 old allowed to nap in playpen when she was able to climb out on her own. The child should have been transitioned to a mat.
110-300-0345(1)	Staff member was not cleared to have unsupervised access to childcare children because her portable background check was expired.
110-300-0345(3)	All staff working that day did not frequently check on the child on the day of the incident, know what the child was doing or position yourselves so that you knew what the child was doing as it was not discovered until much after naptime that the child needed medical attention.
110-300-0106(11)	Staff member supervising children did not have a current First Aid/CPR training.
110-300-0475(3)	Licensee/Provider did not submit an incident report in the 24 hour timeline
110-300-0111(1)	Licensee was not aware that staff may have been sleeping during the children's nap time. Additionally, licensee didn't know that a staff member worked in the office the duration of naptime and wasn't assisting the other staff member with caring for the children during this time.
110-300-0455(2)	Licensee does not have sign in/out record for victim for August 9-17.
110-300-0300(1)(a)	Licensee does not have an individual care plan for child allowed to nap with a bottle, which is not developmentally appropriate and choking hazard.
110-300-0105(2)	Staff member who was caring for children did not have a cleared background check.
110-300-0110(4)	Licensee does not have documentation showing staff have been trained to the early learning program and premises.
110-300-0115(1)	Licensee did not established a system to maintain trainings and portable background check for staff member. The First Aid/CPR cards and portable background check for staff member were expired.

Committee Discussion

The Fatality Review Committee met over two days, December 13 and 14, 2021, following the completion of the LD/CPS investigation and the child care licensing complaint inspection. Committee members were provided with a packet of information, which included the following: the DCYF LD/CPS investigative assessment and case notes regarding this fatality; DCYF Child Care Licensing facility complaint report and case notes regarding this child fatality; DCYF Child Care Licensing monitoring reports from the past five years; and the King County Medical Examiner's Autopsy Report.

Discussions began with a review of case notes, a review of the child care WAC relevant to the case, and five years of licensing history. It was noted that recent monitoring visits for child care licensing were completed virtually due to the COVID-19 pandemic.

Previous monitoring case notes showed a recent pattern of failure to ensure staff had completed background checks, and complaint findings showed that current staff members have expired CPR/First Aid certifications and/or have not received program-related trainings. Concern was expressed at the risk level of these particular non-compliance issues, despite a history of compliance to other WAC. The committee discussed how that may have impacted the critical incident. The review committee was informed that background checks need to be renewed and that the staff had previously provided such documentation but they had expired. DCYF also shared that child care licensing recently shifted practice to a relative risk-level system that includes annual talking points, and it was noted that Safe Sleep practices were not included in the annual talking points.

The committee recommends that Safe Sleep practice be included in the talking points for the licensing monitoring visit every year. The committee discussed whether additional guidance might be needed regarding Safe Sleep practices for children transitioning from toddler to preschool-age. The committee also recommends that DCYF Child Care Licensing work more closely with Early Achievers coaches when staff training and record keeping, or Safe Sleep practice, are an issue of non-compliance, and explore how to connect providers with additional coaching support when the provider does not participate in Early Achievers.

The committee reviewed the information provided about I.J.'s health on the day of the incident, especially during a time of enhanced COVID-19 safety protocols for child care programs, and with regards to her history RCW 74.13.520. It was noted that providers are required to have their own plans in place in response to individual medical needs, and that DOH provide the guidance for child care programs.

The committee reviewed the sleeping equipment used with I.J., and whether it was appropriate for I.J. to be placed in a pack-and-play with a pillow or stuffed animal. The committee confirmed that I.J. should not have been in the pack-and-play due to her weight and age. The committee reviewed relevant WAC regarding Safe Sleep practices for preschool aged children, and recommend that WAC be updated to more clearly require that sleep equipment be used according to manufacturer's instructions and Consumer Product Safety Commission (CPSC) standards. It was also recommended that guidance be provided to ensure Safe Sleep practices described in WAC are followed despite parental preference or presence if the parent is on staff at the program.

Additionally, the committee reviewed the information sent by the Medical Examiner's Office. The actions of the Medical Examiner's Office are outside of the purview of this fatality review committee, but committee members expressed concern at the determination that the child did not suffocate and that LD/CPS did not receive a completed Sudden Unexplained Infant Death Investigation (SUIDI) reporting form or ICD (International Classification of Disease) code. The committee recommends that LD/CPS have a process in place for working with Medical Examiner or Coroner offices to receive more accurate information, if possible.

During the fatality review, the committee also discussed how the parent, provider, and staff may have been supported during the period of multiple investigations, with concern about equitable treatment and bias under the circumstances. The committee requested and reviewed the CPS brochure that was given to individuals under investigation. The committee recommends that translations be provided, and that referral to

grief counseling be included in outreach to individuals involved in a child fatality, even while under investigation.

Recommendations

The committee recommends that:

1. Safe Sleep practice be included in the talking points for the licensing monitoring visit every year.
2. Issues of non-compliance regarding staff training and record keeping be provided to programs' Early Achievers coaches, and DCYF should explore how to connect providers with additional coaching support when the provider does not participate in Early Achievers.
3. WAC 110-300-0290 (3)(a) include a requirement that sleep equipment be used according to CPSC guidelines and manufacturer's instructions.
4. DCYF provide guidance that Safe Sleep practices described in WAC are followed despite parental preference or presence if the parent is on staff at the program.
5. LD/CPS have a process in place for working with Medical Examiner or Coroner offices to receive a completed SUIDI form or ICD code.
6. Translation services be ensured for individuals under investigation by DCYF, and that referral to grief counseling be included in outreach to individuals involved in a child fatality, even while under investigation.