WASHINGTON STATE
Department of
Children, Youth, and Families

CHILD FATALITY REVIEW

February 2019

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FULL REPORT

CHILD

- J.H.

DATE OF CHILD'S BIRTH

- RCW 74.13.515 2018

DATE OF FATALITY

- September 14, 2018

CHILD FATALITY REVIEW DATE

- January 8, 2019

COMMITTEE MEMBERS

- Shelley Little RN, BSN, CCM Benton-Franklin Health District
- Kathleen Clary-Cooke, Health Educator - Injury Prevention Benton-Franklin Health District
- Patrick Dowd, Director, Office of the Family and Children's Ombuds
- Drew Florence, Detective Sergeant, Richland Police Department
- Lisa Anderson, Parent
- Cheryl Hotchkiss, Critical Incident Case Review Specialist, Department of Children, Youth, and Families
- Travis Hansen, Statewide Licensing Administrator, Department of Children, Youth, and Families

FACILITATOR

- Judy Bunkelman, Licensing Monitor & Risk Management Coordinator, Department of Children, Youth, and Families

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A child fatality or near-fatality review completed pursuant to RCW 74.13.640 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 74.13.640(4).

Given its limited purpose, a child fatality or 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 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 and generally only hears from DCYF employees and service providers. It does not hear the points of view of the child's parents and relatives, or of other individuals associated with the child. 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.

EXECUTIVE SUMMARY

On January 8, 2019, the Department of Children, Youth, and Families (DCYF/Department) convened a Fatality Review Committee (FRC) to assess the Department's actions and circumstances surrounding the death of RCW 74.13.515-old J.H.[1] The incident initiating the FRC occurred on September 14, 2018, when J.H. died in a licensed child care family home. The Benton County Coroner completed an autopsy citing no concerns for abuse or neglect to include documenting a lack of marks, injuries, or signs of trauma. Further, the Coroner indicated the likelihood of Sudden Infant Death Syndrome (SIDS); however, toxicology results are pending and the autopsy cannot be finalized until the results are obtained.

The FRC members included a public health nurse, an injury prevention specialist who also convenes child death reviews, a law enforcement officer, a parent who previously experienced the death of her child in child care, the director of the Office of Family and Children's Ombuds (OFCO), a DCYF headquarters employee who conducts child fatality reviews, and a DCYF leadership staff person. One invitee, a child care center director, was unable to attend. No committee member had previous contact or involvement with the family. The parents of J.H. were invited verbally and in writing to testify to the FRC in person, by phone, or in writing. Interpreter and translation services were utilized for communication and offered for their testimony. J.H.'s parents did not respond to the invitation.

Prior to the review, each committee member received a packet of information which included the following: DCYF reports and provider notes spanning the history of the license since March 29, 2016; DCYF Division of Licensing Resources/Child Protective Services Administrative Investigative Assessment; RCW 74.13.515 Police Report; medical records from RCW 74.13.515 Hospital; Benton County Coroner's preliminary findings; the child's files; staff files; and the policies from the family home child care facility. All documents were un-redacted. Supplemental sources of information and resource material regarding DCYF policies, procedures, regulations around safe sleep for infants, and SIDS/Sudden Unexplained Infant Death (SIDS/SUID) were available at the time of the review.

[1] The parents are not identified by name in this report as no criminal charges were filed related to the incident. The name of J.H. is subject to privacy law. [Source: RCW 74.13.500(1)(a)]

CASE SUMMARY

On May 31, 2018, J.H. (infant) was enrolled at the licensed family home child care of Nancy Ramos (doing business as Learning Castle Preschool). From the infant's file, the mother was identified as A.C. The father was not listed on the registration form. The forms are completed in English although throughout the case the parents were identified as primarily Spanish speaking. A three-year-old sibling of J.H. RCW 13.50.100 . From the file, J.H.'s last physical exam date was May 23, 2018. No special health problems, allergies, or medications were identified. Information received from the mother after J.H. died noted that J.H. was seen for a well-child visit on September 12, 2018. J.H. received immunizations and no concerns were noted by the physician.

On September 14, 2018, the assigned DCYF licensor received a call from the provider informing that a RCW 74.13.515 -old child enrolled at her child care facility had died. The provider related that the child was J.H. and when she was dropped off by her mother, J.H. seemed normal. The infant had not been consuming as much as usual for a short time prior to and on the date of the incident, J.H. did not drink her entire bottle at approximately 9:00 a.m. The infant was laid down by the provider on her back for a nap at around 10:30 a.m. The playpen that was used had been previously approved by the licensor and the provider stated that nothing was in the playpen with the infant. The playpen was in the main child care space. At approximately 11:00 a.m., the provider recalled that she checked on J.H. and found J.H. with purple lips and not breathing. The provider called 911 and performed CPR until the ambulance came and first responders took over. The infant was taken to the hospital where rescue attempts were not successful and the child was declared deceased.

The DCYF licensor then called the information into the intake line and a complaint was initiated. An investigator for the Division of Licensing Resources/Child Protective Services (DLR/CPS) was assigned and an investigation ensued. Additionally, the RCW 74.13.515 Police Department responded and made a report.

On September 18, 2018, the RCW 74.13.515 Police Department's report stated that, pending the results of the autopsy, this was being handled as "an attended death of a child."[2] The preliminary autopsy results showed no sign of trauma or medical reason for the child's death. Toxicology results take several months and were not received as of the date of the FRC meeting. The child's primary health care provider stated that it is expected the results will be SIDS.

On December 5, 2018, the DLR/CPS complaint was closed as Unfounded for Negligent Treatment or Maltreatment because "current evidence and information does not indicate J.H. was a victim of abuse or negligence."

On December 6, 2018, the DCYF licensing complaint was closed as Not Valid for Safe Sleep violations because from all evidence received, it appeared the provider was following safe sleep practices at the time of this event.

COMMITTEE DISCUSSION

After discussing the case history and documents provided, the Committee found no critical oversights; the child care provider appeared to have followed Washington Administrative Codes (WACs) regarding safe sleep practices and reporting of serious incidents.

[2] "An attended death of a child" is a police report term that means the child was not alone at the time of death.

The Committee noted that there were discrepancies in the documentation. The time J.H. was put down for a nap was indicated at different times ranging from approximately 9:30 a.m. to approximately 10:30 a.m. and there was a reference to a pair of pants being in the playpen at the time the infant was sleeping versus a clear sleeping area. From the available information, these discrepancies were not able to be reconciled. However, after discussion, it was concluded that given the information provided these inconsistencies did not appear to be a factor in the child's death.

The Committee reviewed WAC requirements regarding supervision of sleeping children. Documentation supports that the provider was following the requirements by having the infant in an area where she could see and hear the infant, checking on her frequently, and having sufficient lighting to observe the child's coloring. At one of the provider's checks on the infant, she noted that the infant had spit out her pacifier. The Committee noted that a pacifier is a protective factor in the prevention of SIDS but is not a requirement of WAC.

Toxicology results were not available and so the cause of death has not been determined. The Committee discussed that toxicology results often take many months to obtain and the autopsy results cannot be finalized until these are returned. Recognizing the opinion regarding the procedure of outside agencies is not within the purview of this review, some Committee members voiced the importance of noting the multi-agency impacts of the delays in obtaining lab results across the state.

Again recognizing the limits of the FRC, minor discussion regarding law enforcement practices of interviewing other children in care and in-depth interviewing of the provider ensued. The Committee heard from the law enforcement representative and licensing staff that interviewing other children would be situationally dependent and, in this case, the other children in care at the time of the incident were preschool age. Also noted was that the report received from law enforcement was the narrative only and for future reference, the request should be for all documents and pictures associated with the case.

A question as to closure requirements for providers after the death of a child in the care facility was raised. In this situation, the provider chose, with support from licensing staff, to voluntarily close for a week. After discussing the merits of requiring a closure, the Committee heard that closure decisions are situational and generally depends on whether child abuse or neglect has occurred or whether there is a significant safety issue. The considerations of the type of facility, the impact on other families enrolled at the facility, the impact to the child care business, and DCYF's authority to suspend a provider's license were all discussed.

The Committee had the opportunity to ask questions of the DCYF licensor. The licensor explained that this provider had an excellent licensing history. Facility monitoring visits have been conducted timely and with few deficiencies noted. The provider has quickly responded to licensing requirements (when found out of compliance) and other requests for information. The licensor was asked if there had been any concerns regarding the children's sleep environment and she advised there had not. The licensor was familiar with the playpen used for sleeping and its placement location in the home and found that it met WAC requirements regarding safe sleep for infants. The licensor was unaware of and unable to explain the inconsistent reporting of the time the infant was put down for her nap and was unaware of any report of the pants being in the playpen.

The Committee recognized that the documentation provided by the licensor's notes was well written, entered timely, and provided the information that supported the conclusion that both the licensor and the provider followed procedures. From that documentation as well as other reports, it was apparent the provider provides good care to the children. Other positives noted by the Committee included the response time from emergency responders was excellent and

there appeared to be positive interactions between agencies that facilitated communication and understanding of the situation. Additionally, it was noted that the licensing staff provided emotional support for the provider throughout the initial impact of the incident. The Committee also noted that DCYF provided peer support to the licensor immediately following the incident.

FINDINGS

There were no findings related to this review.

RECOMMENDATIONS

There were no recommendations specific to DCYF's rules, policies, practices, or procedures.