Washington State Department of Early Learning

Child Fatality Review
L.F.

July 18, 2015
Date of Child's Birth

February 16, 2016
Date of Fatality

July 11, 2016
Child Fatality Review Date

Committee Members
LuAnn Afifi, Center Director, Bright Horizons Family Solutions
Lisa Anderson, Parent
Patrick Dowd, Director, Office of the Family and Children's Ombuds
Chief Deputy Dave Pearsall, Thurston County Sheriff's Office

Observer(s)
Gabe Ortiz, Licensing Analyst, DEL North Central Region
Deanna Sundby, Licensing Analyst, DEL Northwest Region

Facilitator
Ann Radcliffe, Licensing Analyst, DEL Southwest Region

Chair Person
Ross Hunter, Director, Department of Early Learning

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Executive Summary

On July 11, 2016, the Department of Early Learning (DEL) convened a Fatality Review Committee (FRC)[1] to assess the Department's actions and the circumstances surrounding the death of almost-7-month old L.F.[2] The incident precipitating this review occurred on February 16, 2016, when L.F. died in a child care center. The Pierce County Medical Examiner stated the cause of death was Sudden Unexplained Infant Death (SUID) with manner of death Undetermined.

The Fatality Review Committee members included a child care center director, a law enforcement officer, a parent who had previously experienced the death of her child in child care, as well as the Director of the Office of the Family and Children's Ombuds. No committee members had previous contact or involvement with the family. Two invitees were unable to attend: a representative from the Department of Health and a person specializing in SUID/SIDS. Parents of L.F. declined the invitation to testify to the Committee in person or by phone; however, an email with their recommendation was received and read aloud during the review meeting.

Prior to the review, each committee member received a packet of information including the following: DEL reports and Provider Notes spanning a five-year history of the center; DSHS Children's Administration Investigative Assessment; Tacoma Police Department Incident Report; Pierce County Medical Examiner's Report and Toxicology Report; and the child's file, child care center staff files, and center handbook. All documents were un-redacted. Supplemental sources of information and resource material regarding DEL policies, procedures, regulations around safe sleep for infants, and SIDS/SUID were available at the time of the review.

The Committee interviewed the DEL Licensor and DEL Licensing Supervisor who were assigned to the case at the time of the fatality to gain an understanding of protocol around sharing of information between departments as well as questions regarding the center's video, photographs and possible requirements for infant sleep sacks.

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[1] Given its limited purpose, a Fatality or Near Fatality Review by the Department of Early Learning (DEL) should not be construed to be a final or comprehensive review of the circumstances surrounding the death of a child. A review is generally limited to documents in the possession of or obtained by DEL or its licensed providers and the panel may be precluded from receiving some documents that may be relevant to the issue in a case because of federal or state confidentiality laws and regulations. A review panel has no subpoena power or authority to compel attendance. A Child Fatality or Near Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, medical examiners or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's death. Nor is it the function or purpose of the review team to take personnel action or recommend such actions against DEL employees or other individuals. Information discovered through the review may be used in DEL disciplinary actions such as revocation or suspension of a child care license.

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

Case Summary

On October 10, 2015, L.F. (infant) was enrolled at Multicultural Child and Family Hope Center; his first day of care there was January 19, 2016. L.F.'s file indicated his last physical exam was September 18, 2015, and noted a milk allergy; he was also taking a multivitamin; and no special health problems noted in enrollment files except for a port wine stain (birthmark). Parents were identified as T.F. and R.F; mother T.F. signed the Parent Orientation form on October 20, 2015, stating she received and understood the Parent Handbook policies.

On February 16, 2016, Children's Administration received an intake regarding the death of a 7-month old infant, L.F., who died while attending a child care center in Tacoma. The report was screened in to the Division of Licensed Resources/Child Protective Services (DLR/CPS) and assigned to an investigator. DEL Licensing was notified and acknowledged the intake. The referrer stated L.F. was placed in a crib on his back for a nap in the infant room. Staff stated that L.F. was known to flip over onto his stomach to sleep as that was what he preferred. In the room were seven children and two permanent teachers with two additional teachers floating between the sleep rooms. Staff stated they checked on him "around three times" between approximately 1:00 and 3:00. Reportedly when 7 month old L.F. was being awakened from his nap he "felt very warm" and did not respond to verbal prompts. There were no pillows or blankets around his face. Referrer reported that a contract monitor was in the hall and went into the room to provide CPR assistance to L.F. while other staff members called 911. Then a staff member took L.F. to the front office and another staff continued CPR. Upon arrival, the emergency response tried to revive L.F., but unfortunately the child never regained consciousness. Referrer reported that the emergency response indicated that L.F. did not have any blockage in his airway such as vomit or any other foreign object. Law Enforcement came to the scene as well as the child's parents. Initial cause of death given that day was Sudden Infant Death Syndrome (SIDS).

On February 17, 2016, additional previous medical concerns were revealed in the interview process with the child's doctors (failure to thrive as an infant, acid reflux). Parents noted that after L.F.'s six-month checkup he was diagnosed with Torticollis[3], but was receiving physical therapy to strengthen his neck muscles; they didn't tell the center because it wasn't a problem for him. No correlation was made with this in the medical examiner's report. When the parents were interviewed by DLR/CPS on April 29, 2016, they discussed their concerns about the center, including: center staff seemed frustrated with L.F., L.F. ate little at the center, yet ate well at home, center staff should have checked on him more frequently during his nap, and the crib sheet had a black mark on it.

On April 29, 2016, the Medical Examiner's Report was issued; the cause of death was listed as Sudden Unexplained Infant Death (SUID) and the manner of death as Undetermined.

[3] A condition in which a baby's neck muscle is shortened; this brings the baby's head down and to one side (WebMD)

On May 5, 2016, the DLR/CPS complaint was closed as Unfounded for Negligent Treatment or Maltreatment as there was "insufficient evidence to show that there was an act, or failure to act that 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, and safety."

On June 3, 2016, the DEL complaint was closed as Not Valid for Health/Safety "because the licensor determined that WACs regarding infant safe sleep practices were followed by infant room staff when putting this child down for a nap."

Committee Discussion

After discussing the case history and various documents provided, the Committee found no critical oversights; the child care center and staff appeared to have followed Washington Administrative Codes (WACs) regarding infant safe sleep practices. The Committee discussed the practice of having employees who are related working in the same classroom, as was the case in this infant room (mother and two daughters). There is currently no WAC that prohibits this; however, some centers do not allow it, per company policy.

The question of "frequency" in checking on sleeping infants came up and Committee members discussed the National Association for the Education of Young Children (NAEYC) recommendation to check on sleeping infants every 15 minutes. As mentioned previously, the parents of L.F. chose not to testify to the Committee in person or by phone; however, an email from the mother was received with the following: "Knowing there are not any laws that require child care providers to check on babies throughout their naps is unacceptable to me. I will always have questions regarding if my son had been checked on throughout his nap, would he still be alive? Maybe he would have had a chance to be resuscitated?"

While the investigation records failed to show any medical condition that was undisclosed to the center that related to the cause of death in this matter, the Committee discussed the idea of updating child records to highlight any medical issues and how to help parents understand that they should not be refused service if they disclose all issues to a child care facility. Certain committee members disclosed that at times, and due to the limited availability of infant child care in this state, parents were often fearful that disclosure of certain medical conditions could prevent the family from securing quality infant child care. Therefore, it was suggested that a face-to-face meeting with parents should take place after enrollment to allay this fear. In addition, the Committee discussed having ALL staff at a site being made aware of all the medical issues, including changes after enrollment.

One committee member stated that in her experience, reporting agencies in various counties have different ways of identifying infant deaths. Some may call them SIDS, some may label them SUID, SUDC, or something else. This may be confusing to parents and the public.

The Committee had the opportunity to ask questions of the DEL Licensor and DEL Licensing Supervisor. They were asked about the use of "sleep sacks," and the DEL licensor described how the one used in this case allowed the infant's arms to move freely and zipped up from the bottom; she stated that no special training is needed for using these. A committee member said they may be used for children up to 24 months old. The Committee asked about having relatives work in the same classroom, with the concern that family members may have - or appear to have - a conflict of interest with the overall safety of the children vs. dedication to family members. The licensor stated the main teacher was the mother of the two other teachers in the infant room. The Committee asked about the child care center's video that could not be viewed by DEL due to computer software requirements needed to do so. The licensor said the DLR/CPS investigator told her the video did not have a clear view of L.F.'s crib on the day of the incident and thus, was not useful to the investigation. The Licensing Supervisor said there were inefficiencies with the exchange of information between DLR/CPS and DEL. Information obtained from DLR/CPS was not available for DEL; because of this, the process of gathering all the information pertinent to the inspection was halted at one point.

Some additional comments and observations noted by the Committee: the DEL Licensor's notes were well-written and entered timely. The Pierce County Chaplains were very helpful and supportive of both the parents and staff; they came to help on the day of the incident as well as several days following to offer assistance and comfort. One committee member stated that chaplains are "not just helpful, but critical" in these situations.

Findings: None

Recommendations

1. The Committee recommends the Department define how frequently sleeping infants should be checked, in centers and family home child cares. In addition, DEL should provide information about this to Family, Friend and Neighbor (FFN) providers.
2. The Committee recommends the prohibition of relatives in centers working in the same classroom (this would not apply in family homes).
3. Although not relevant to this particular case, the Committee recommends better sharing of health information; make this easy for parents to share without risk or fear of their child not being accepted into enrollment. Perhaps ask or require parents to give updates after well-baby checkups.
4. The Committee recommends that DEL get full access to all the information about a fatality from other state agencies (such as DLR/CPS), law enforcement, etc., including any available videos or pictures from a facility, and share this information with the family.
5. The Committee recommends changing the variances between counties on how they report on SIDS, SUID, SUDC, etc.

6. The Committee recommends looking into further study about what happens with safe sleep rules AFTER the child passes 12 months (e.g., should blankets, bumpers, stuffed animals be allowed, once a child is one year or older?).