Washington State Department of Early Learning

Child Fatality Review
R.N.

October 12, 2015
Date of Child's Birth

May 10, 2016
Date of Fatality

October 18, 2016
Child Fatality Review Date

Committee Members
Cathy Meuret, Chelan-Douglas Health District
Christal Eshelman, Chelan-Douglas Health District
Lisa Anderson, Parent
Cristina Limpens, Office of the Family and Children's Ombuds
Kevin Files, Chelan County Sheriff's Office
Michelle Hedges, Supervisor, Children's Administration

Observer
Ann Radcliffe, Organizational Change Manager, Department of Early Learning

Facilitator
Gabe Ortiz, Licensing Analyst, DEL North Central Region

Washington State Department of Early Learning

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Executive Summary

On October 18, 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 R.N.[2] The incident precipitating this review occurred on May 10, 2016, when R.N. died in a licensed family home child care.

The Fatality Review Committee members included a supervisor from Children's Administration, two representatives of the local health district, 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. Parents of R.N. were invited to testify to the committee in person or by phone; however, no response was received.

Prior to the review, each committee member received a packet of information including the following: DEL reports and inspection checklists spanning the last two years of the family home's licensed history; Douglas County Sherriff Office Incident Report; and a copy of facilities policies and procedures. 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.

[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 R.N. is subject to privacy law. [Source: RCW 74.13.500(1)(a)].

Case Summary

On March of 2016, R.N. (infant) was enrolled at the licensed family home of Gabriel and Mallorie Vasquez. A review of R.N.'s medical file by investigating Officer Scott found no health concerns. Parents were identified as J.N[2]. and O.N[2].

On May 10, 2016, the Department of Early Learning supervisor received a telephone call from the provider advising that she had found R.N unresponsive and the child had been transported to the hospital. The DEL supervisor advised the provider to report the incident to Children's Administration Intake. Intake was received by Children's Administration and screened in for investigation; however, after further review, the decision was made to screen out the referral for licensing violations only. Incident report noted that at approximately 12:00 pm, provider found R.N. face down and unresponsive. Provider stated R.N. was placed in a bassinet on her back for a nap in the bedroom used as the sleeping area. Provider stated that R.N. liked to roll over. Provider stated that when she went to check on R.N and saw the infant lift her head up, she thought R.N. was waking up, but the infant went back to sleep. The next time she checked in on R.N. she noticed the infant was unresponsive and not breathing. Provider picked up R.N. and found her to be limp. CPR was administered to the child while emergency services were contacted. When the ambulance arrived, life saving measures continued and the child was transported to Confluence Health Hospital. At approximately 12:36 pm emergency room doctors determined R.N. was deceased and stopped medical treatment. The Investigative Report indicated that no items were found inside the child bassinet.

On May 11, 2016, an autopsy was conducted and it was noted that no signs of trauma were evident. The child appeared to be of the proper size and weight for the age. Official cause of death was pending toxicology report results.

On July 18, 2016, the DEL complaint was closed as Not Valid for Infant Safe Sleep practices "because the licensor determined that there is no evidence to show that the licensee was not following safe sleep requirements. Detective Scott stated that this was a SIDS death."

Committee Discussion

After discussing the case history and various documents provided, the Committee found no critical oversights; the family child care home and staff appeared to have followed Washington Administrative Codes (WACs) regarding infant safe sleep practices.

The Committee focused on the reasoning behind DLR/CPS not investigating the fatality and instead screening it out for licensing violations. Members felt that in any fatality, a thorough investigation should be done and felt that perhaps a licensor might not have the necessary investigative skills necessary to capture any underlying issues that might be present. One committee member stated that perhaps a document should be created detailing the specific roles and responsibilities agencies should have in the event of a fatality.

The Committee discussed the flow of information between agencies in the event of fatalities and the complexity of knowing who to contact to obtain reports. Due to the different jurisdictions present, it can become difficult to obtain the necessary documentation needed to conduct a proper inspection/investigation.

The Committee had questions regarding the rules and regulations that covered how often an infant is checked on while napping. They suggested that these rules and timeframes should be more clearly defined.

The Committee had the opportunity to ask questions of the DEL Licensing Supervisor and DEL Licensor assigned to the case. Both Supervisor and Licensor noted that the purpose of the inspection was to look into any licensing violations rather that the fatality itself, so their role was limited. Licensors are used to allowing DLR/CPS and Law Enforcement to take the lead in fatality cases and since in this case DLR/CPS chose not to investigate, standard protocols were unclear. The DEL Supervisor stated that when the incident occurred, staff were traveling from a meeting and had a little trouble with initial communication with the provider. One committee member asked if any services were provided to DEL staff to support/ensure their mental wellbeing during the course of the inspection.

Some additional comments and observations noted by the Committee: The hospital chaplains were very helpful and supportive of both the parents and staff. One committee member stressed the importance of ensuring care is taken not to state SIDS can be prevented, but rather that steps can be taken to reduce the risk of SIDS by creating a safe sleep environment.

Findings: None

Recommendations

1. The Committee recommends a better system to request and obtain pertinent information from agencies involved in fatalities. (i.e., coroner's report, toxicology report).
2. The Committee recommends a document be developed by DEL that details the roles and responsibilities the agency must take in the event of a child fatality, including an emergency response call tree or communication chain of command.
3. The Committee recommends the Department clearly define how frequently sleeping infants should be checked, in centers and family home child cares.
4. The Committee recommends more communication with providers, parents and staff regarding safe sleep practices. Suggestions include: facilitated provider meetings, sharing of licensing violation trends, visual aids such as safe sleep posters given to providers, safe sleep brochures to share with parents, and requirements for more focused safe sleep practices in provider policies.
5. The Committee recommends training between law enforcement, DLR/CPS, and DEL staff highlighting joint cooperation during an investigation.
6. The Committee recommends implementation of a support system for licensors to ensure mental wellbeing.
7. The Committee recommends the time requirement of certifications such as CPR and First Aid be based on Department guidelines rather than the issuing programs. Suggestion was made for a one year timeframe on all certifications in order to ensure skill is current.
8. The Committee recommends providers engage in a recurring, documented self-assessment of safe sleep practices.