Washington State Department of Early Learning

Child Fatality Review
S.O.S.

August 7, 2014
Date of Child's Birth

July 22, 2016
Date of Fatality

December 7, 2016
Child Fatality Review Date

Committee Members
Tamara Rohrback**,** Center Director, Kids Country Maple Valley
Patrick Dowd, Director, Office of the Family and Children's Ombuds
Laura Asbell, Sergeant Detective, Issaquah Police Department
Bat-Sheva Stein, Perinatal Nurse, WA State Department of Health

Observer(s)
Gabe Ortiz, Licensing Analyst, DEL North Central Region
Sonya Stevens, Licensing Analyst, DEL Eastern Region

Facilitator(s)
Travis Hansen, DEL Early Learning Statewide Licensing Administrator
Deanna Sundby, Licensing Analyst, DEL South King County Region
Ann Radcliffe, DEL Organizational Change Manager

Washington State Department of Early Learning

Table of Contents

Executive Summary

On December 7, 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 23-month-old S.O.S.[2] The incident precipitating this review occurred on July 22, 2016, when S. O. S. died in a child care center. On July 24, 2016, a detective from the Bothell police Department stated the child died of natural causes, a twisted colon causing suffocation to his arteries; he also stated that there was no indication of child abuse or neglect.

The Fatality Review Committee members included a child care center director, a law enforcement officer, a perinatal nurse from the Washington State Department of Health and the Director of the Office of the Family and Children's Ombuds. No committee members had previous contact or involvement with the deceased child's family. Under RCW 43.215.490, the meeting organizer invited a parent who had previously experienced the death of a child in child care; however, that parent was unable to attend. During the Committee proceedings the deceased child's parents testified in person for approximately one hour.

Prior to the review each committee member received a packet of information including the following:

1. DEL reports;
2. Complaints;
3. Provider Notes spanning a five-year history of the center;
4. DSHS Children's Administration Investigative Assessment of the fatality; and
5. The child care center facility handbook.

All documents were un-redacted. At the time of the committee meeting supplemental sources of information and resource materials were made available to the committee, including the following:

1. Chapter 170-295 WAC (Minimum Licensing Requirements For Child Care Centers);
2. Copies of the deceased child's registration form;
3. Copies of witness statements from two teachers employed at the child care center;
4. Facility Licensing Compliance Agreement (FLCA); and
5. Supervisory Review Decision letter regarding various Valid licensing issues that originated from a July 22, 2016 inspection.

[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 and deceased child (S.O.S) are not identified by name in this report.

DEL was unable to obtain copies of the Bothell Police Report, the Medical Examiner's Report, and the Toxicology Report. The Committee interviewed the DEL Licensor and DEL Licensing Supervisor assigned to the case at the time of the fatality. The Committee also heard testimony from S.O.S.'s mother regarding her account of the event as well as a number of recommendations from both her and the father of the child.

Case Summary

On July 7, 2016, S.O.S. was enrolled at Kids Corner Childcare Center in Bothell. His first day of care at the facility was July 11, 2016. The child care center's registration form for the child indicated his last physical exam occurred on August 11, 2015. There were no allergies or special health problems noted in the child's enrollment papers. The parents were identified as K.S. and H.O. J. The mother, K. S., signed the enrollment form on July 7, 2016, affirming she received a copy of all the child care center's policies.

On July 22, 2016, Children's Administration received an intake with allegations of Negligent Treatment/Maltreatment of a 23-month-old child, S.O.S., who died while attending a child care center in Bothell. The report was screened in to the Division of Licensed Resources/Child Protective Services (DLR/CPS) and assigned to an investigator. The intake reported that the referrer was the director at Kids Corner Childcare. However, according to the reports, the director was not present at the time of the fatality. The director reported that S.O.S. was dropped off for care at 5:30 a.m. on July 22, 2016, and appeared to the center teachers to be sleepy. The director said the mother told the classroom teacher that S.O.S. had a "bad night." The teachers laid out a mat and gave the child his blanket and he went to sleep. The director reported the child was not engaging in any activities so they called the mother and asked her to pick up the child as he was clearly very tired. The director reported that at approximately 8:40 a.m. the child would not wake up and was unresponsive. The paramedics were called. Despite their efforts, medics were unable to resuscitate S.O.S. and he died at the facility. The director reported that the Bothell Police Department was conducting an investigation.

On July 22, 2016, Detective Chissus from the Bothell Police Department called and stated that an autopsy was scheduled for July 23, but "at this time [the] death is being ruled as suspicious." On July 24, 2016, Detective Chissus called and stated that an autopsy was conducted and S.O.S. "died of natural causes, a twisted colon causing suffocation to his arteries." He also stated that there was no indication of Child Abuse or Neglect.

On July 25, 2016, Detective Chissus provided information to the CPS investigator about his conversation with the mother of the child, who stated that S.O.S. had been sick over the weekend but had improved with only constipation as a concern. She had given S.O.S. some apple juice and he had two bowel movements. His condition seemed to be better. On Friday they left home early to get to daycare. The drive took longer than normal so he did appear crankier than usual. The mother said she told the daycare about her son's status and he was laid down to rest. She said he did not appear sick and did not have a fever.

On July 27 the DLR/CPS investigator requested a Medical Consult from Dr. Becky Wiester, Seattle Children's Hospital. This doctor did not treat the child, nor did she review the medical documentation related to the incident. Her information was based on how a typical child would appear with this condition. She stated that he should have appeared to staff as being in shock, looking grey and sick. She

said “without treatment the overall outcome would have been the same.” She said she suspects the night before the child would have been in excruciating pain with vomiting, and crying hysterically.

On July 29, 2016, the DLR/CPS investigator spoke with Det. Chissus. The detective stated there was no suspicion of abuse or neglect following the Medical Examiner’s report. He stated he would not be closing the case due to the fact that he was waiting for the final toxicology results. He gave the DLR/CPS investigator permission to proceed as needed.

On August 2 and August 11, 2016, on-site interviews were completed with the two teachers who had been present at the time of the incident as well as the director who had not been present. On August 11 a certified interpreter was present for interpretation services during the interview of one of the teachers. The DEL licensor and DLR/CPS investigator were also present for the interviews. Several issues arose from these interviews. The “Issues and Concerns Noted” section of the Investigative Assessment said the following: “It is a concern that: only one staff member was on site early in the morning; staff needed director or assistant director’s permission to call parents for a sick child; staff stated the expectation was to contact the director prior to 911 in event of an emergency; staff could not reach the director or assistant director during the medical emergency; staff leave children in the room to unlock the front door; the only way to secure the front door is through a deadbolt; an employee was rehired after being terminated for hitting a child; staff were not supported during the traumatic event; a child died at the facility; mother reports that she had to direct staff to call 911; mother tells a much different story as to how the events unfolded than the staff members.” One item was listed under “Description of Strengths and Protective Factors”: “Staff determined that the child did not seem right, and called the mother.”

DEL cited the child care facility with the following Valid licensing issues: WAC 170-295-0070 (1)(c) regarding Character; and WAC 170-295-3010(2)(c) and WAC 170-295-3010(3)(c) regarding Health Policies. On August 11, 2016 the DEL licensor went to the facility to follow up on the incident and found two additional licensing violations. The additional cited violations involved violations of WAC 170-295-2909(4) regarding Supervision, and WAC 170-295-5020(1)(a) regarding Facility Environment.

On September 15, 2016, the DLR/CPS investigator received a phone call from K.S., mother of the deceased child. She stated she received the DEL records and was concerned that the facts contained in the records were incorrect, specifically the events timeline regarding when she was called and when 911 was called. She also stated the staff who called 911 told her she had to find the address of the center to provide it to the operator. She believed that had staff acted two hours earlier, S.O.S. may still be alive.

The DLR/CPS assessment was completed on September 27, 2016. The determination was entered as Unfounded for the allegation of Negligent Treatment or Maltreatment of child, S.O.S. The report states “there is no evidence that there was an act or a failure to act on the part of the child’s parent, legal custodian, guardian, or caregiver and shows 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. Given that there was no subject identified it was determined that the director of the facility, Ms. Nicole Pelham, would be listed as a subject and received the DLR/CPS Directors letter. During the investigation it was determined that S. died of natural causes, and staff is not negligent in their actions. When it became apparent that S. needed medical help staff took appropriate actions to get him the help he needed. S.’s mother had reported that he had a difficult night the night before and his sister stated he had been

acting like he needed to poop all day. According to staff reports, S. was not acting like he was in acute distress until the decision was made to call 911. S. was not running a fever, was not throwing up and was not crying hysterically."

On October 13, 2016, DEL cited the child care facility with the following Valid licensing issues: 170-295-0070 (1)(c); 170-295-3010(2)(c) and 170-295-3010(3)(c). Reasons for the valid findings:

- First valid issue: "Staff persons did not immediately telephone emergency medical services when they observed a child was lethargic, pale, and bluing around the lips."
- Second valid issue: "Immediately following his arrival at 5:30 a.m., the child who died while in care presented as unable to stay awake or sleep for any period of time, listless and had an overall appearance of not feeling well, the Center's approved Health Policies state that children with 'fatigue that limits participation in daily activities' and a 'sick appearance, not feeling well, and/or not able to keep up with program activities…will not be permitted to remain in care.' The parent was not directly requested to pick up their child due to a staff person's belief that she was required to obtain management approval prior to asking a parent to pick up an ill child."
- Third valid issue: "The Center's approved health policies state 'Children with any of the above symptoms/conditions are separated from the group and cared for in office or empty class. Parent/guardian or emergency contact is notified to pick up child.' The child was not isolated in this manner by Center staff."

Because Director Nicole Pelham disputed these Valid findings, a Supervisory Review was requested on November 14, 2016. In addition, she stated she "would like to launch a formal complaint about Julia Dunham (licensor)."

Committee Discussion

After discussing the case history and reviewing various documents, the Committee had several questions for DEL staff present at the meeting. One question was about whether DEL requires facilities to keep their own center policies as well as comply with the licensing WACs; in this case, regarding an ill child. The answer: DEL regulates per RCW and WAC. The committee noted there were different timelines and different versions of the day's events as told by the two classroom teachers versus the director of the facility. One teacher reported that they must have management permission to notify a parent that a child needed to be picked up. The director denied this.

Regarding the site's licensing history: one committee member stated that it seemed like the director was absent a number of times during licensing visits and perhaps did not take the valid licensing issues seriously. Another committee member said it appeared as though the facility had a fairly good licensing history from 2011 through 2014, but after that time there were increasingly more issues (e.g., lack of training for staff, hiring back staff with negative history, etc.).

The Committee asked about frequency of licensor visits. DEL staff stated that each facility receives at least one monitoring visit every 12 months, but that additional visits may occur for follow-up issues, technical assistance, and/or complaints. Committee members stated that it appeared the relationship between this director and DEL had become adversarial. One member said they expected to see better compliance after the incident, but in this case, the director displayed an "odd" reaction in that she did not want to communicate with licensing. The practice of "self-reporting" was discussed as well as the severity of certain WAC violations, or "weighting" of WACs, which the agency is currently in the process of doing.

One Committee member asked about the caseload numbers per licensor. The DEL Statewide Licensing Administrator stated that in this licensing office, the caseload is slightly higher than others. In addition, the number of complaints is higher for center licensors. The DEL Statewide Licensing Administrator gave a brief overview of what would happen after a fatality. That is, once a complaint is generated through Children's Administration and is screened in through DLR/CPS, DEL staff goes out to do a joint inspection with the DLR/CPS investigator. Committee members asked about the use of interpreters during interviews. DEL staff replied there is a requirement that interpreters must be provided from a contracted agency and not allow centers to provide another staff member to interpret for a co-worker. A committee member noted there were several discrepancies about the timeline of events and asked if DEL is allowed to audio-tape interviews. The answer was no. One Committee member stated that in case of fatalities, it might be good to have an exception and allow the conversations to be taped for accuracy.

Committee members noted the apparent time lag for the director of the facility to report the fatality to CPS. However, others in the group pointed out there was also a major fire in Bothell that same morning and there was a lot of media activity as well as multiple emergency vehicles in the area. Members also discussed an apparent lack of consistency in the way various witnesses described the condition of the child: sleepy versus really in distress, moaning, etc. One committee member wondered if it had been difficult for the teachers to have to call the director first to get approval to call the mother of the child. The committee member speculated that the teachers felt the director would be mad at them. DEL staff was asked if a video was taken of the child care center. The staff reported that there was a video. However, it was reportedly poor quality and did not provide any information about the incident. Therefore it was not obtained by DEL.

A Committee member with medical expertise commented that the cause of death was unclear to her. According to the Investigative Assessment, the Detective for the case stated that "an autopsy was conducted and S. died of natural causes, a twisted colon causing suffocation to his arteries…[with] no indication of CA/N". However, as she pointed out, children may have different reactions. This child did not lose consciousness, but if so, one could expect staff to call 911. Another Committee member stated the sister of the child pointed out the fact that S.O.S. had also acted constipated the previous day. The mother thought the child had sufficiently recovered to attend the child care. Committee members discussed the decision-making ability of the child care teachers in cases of illness, whether or not it mattered that there were only two staff in the child care at the time, and how soon the parents and/or 911 were called. Committee members observed that the time of day may have been a factor in the child's sleepiness as it was very early (5:30 a.m.) when he was dropped off.

Committee members discussed the statement that was made by one of the child care workers in the room at the time regarding the temperature and color of S.O.S's skin. This teacher reported that S.O.S's skin was light gray/brown in color when a parent came into the classroom about 7:30 and felt S.O.S's skin and "agreed that he felt cold to the touch." The same teacher said she was not sure what time 911 was called but that the paramedics and S's mother showed up at the same time.

DEL staff pointed out that the licensing WACs require an emergency plan when the director is off-site. The Committee noted that the facility director stated it was NOT their policy to call her first but this contradicted what the staff said. A Committee member asked if there was a time requirement for

reporting. The answer was yes. Although the incident occurred on July 22, the director did not submit an incident report form until August 4. The Committee also discussed the form and how a special form might be used for fatalities as opposed to injuries. They also asked how often a licensor would go to visit the facility after a fatality. DEL staff reported there is no policy on this. Next, a Committee member asked how many citations would be required to shut down a facility. The Statewide Licensing Administrator answered that it depends on the severity of the violation as well as tracked history of violations.

The Committee had the opportunity to ask the following questions of the DEL Licensor(s) and DEL Licensing Supervisor. These are listed below with Q for question and A for answer.

1. Q: Had this director ever "self-reported" an incident before? A: No.
2. Q: How was the communication between the director and the licensor? A: Previous licensor said "always open." Current licensor said "minimal contact, defensive."
3. Q: Had there been previous instances where staff felt the need to call the director in a case of emergency? A: No.
4. Q: How many times has the current licensor (Julia) been out to the facility since the incident? A: Two or three times with CPS.
5. Q: Why did it take so long to get the incident report? A: Licensing Supervisor said there was a large fire in Bothell that day and he asked the licensor to check in with her licensed sites. It was then when she found out about the fatality. Licensor stated that the report "may have gotten lost in the shuffle" and was probably not intentional.
6. Q: How did the inspection go with DLR/CPS? A: Licensor said it went well.
7. Q: Why wasn't the extra parent interviewed? A: Licensor did not recall an extra parent being referenced.
8. Q: Are the same staff still working at this center? A: Licensor stated she thinks they are.
9. Q: Was there any offer to help with support? A: Licensor thought the health nurse did reach out to staff with handouts and grief support.
10. Q: Have there been any repeated violations since the fatality? A: Deadbolt on the front door; however, this has been fixed with an alternative way for parents to gain entry

The current licensor and supervisor were also asked about the claim by staff that they needed approval from the director before contacting parents. The licensing supervisor said Nicole denied the practice. The licensor said they didn't hear anything more about this because the compliance agreement was still under the Supervisory Review process. A Committee member asked the licensor if the Director, Nicole, had been distraught that day. The licensor answer was no. She said she acted "annoyed, defensive, eye-rolling, and not professional." The licensor stated, "It's odd that they chose to remain open this day. I think it's offensive they continued to answer the phone with the message, 'It's a great day at Kids Corner.' The tone was interesting."

Finally, another committee member asked the licensor, "If a facility had a policy about naming a person to have the authority to call in an emergency, would this be in a writing somewhere? The licensor said, "I would never approve something like that. Everyone has the opinion 'just call 911.'"

Parent Testimony

Next, the mother and father of the deceased child came before the Committee to testify about the events of that day and to give their recommendations. The father H. O. J. and mother K.S. passed

around photos of their 23-month-old son, S., and described his characteristics and favorite activities. K.S. read a prepared statement of the July 22 events. She said she dropped him off around 5:30 a.m. and at 8:11 she received a phone call from Kids Corner. She called them back at 8:21. They said he wasn't crying but very sleepy. There had been a large fire in Bothell that morning. K.S. said the classroom teacher didn't call 911; however, a front staff person finally did once she got there. K.S. said the front desk person didn't know the address of the facility. She stated her child's skin was cold and pale in color. EMT workers could not revive him. During this time, the other classroom teachers left the rest of the children in the classroom and finally moved them after S. passed away. K.S. said she was asked to move to another room where there was a mini-refrigerator. She said she was shown no compassion as workers kept coming in and reaching around her into the refrigerator.

K.S. stated the medical examiner called to tell her that her child had had a birth defect called Volvulus. According to what was told to K.S., this condition was treatable but not detected. Since the incident, only two staff members expressed their condolences to them. When K.S. asked Director Nicole why 911 wasn't called, she reportedly said, "I don't know. I wasn't there." K.S. said no one since then has reached out to her. No apology, no words, no answers to her questions. She stated the center displayed incompetency, a lack of compassion, and serious negligence. She said if anyone had seen her son in that condition, they should have called 911 (before 8:11 am) and he could have been saved. She further stated, "We need to be sure the people who care for our children are prepared to deal with these kinds of incidents. They swept it under the rug. They need to recognize the mistakes that were made and correct them."

K.S. also asked if the "DEL report [was] correct and final." She said the reports and statements from the teachers were inconsistent and shocking to her. Mistakes were made and "people should be accountable." She asked how this facility could still remain open. Committee members asked if this was the first opportunity for her to share her feelings and she said yes. When asked if she had been given any support, other than interviews, she said: "Yes, the lead detective. Also DCS gave resources to contact. I felt disrespected by the child care; I felt they were advised by a lawyer not to respond."

The Committee asked for the parents' recommendations; these are listed below (numbers 1-3 under "Recommendations"). The Committee thanked the parents for their testimony and they left.

The Committee also gave the remainder of their recommendations which are listed below under "Recommendations" (numbers 4-10).

Findings: The Committee found that:

1. There were delays in calling 911 (noted in DEL's compliance agreement).
2. There was confusion between center staff and the director regarding when to notify the parent of an ill child (noted in DEL's compliance agreement).
3. The child care facility remained open after the fatality; this caused anguish to the family of the deceased child.

Recommendations:

1. Recommend training for child care workers to be prepared and know how to react in an emergent situation.

2. Recommend that the address of each child care facility and emergency numbers be posted in plain view in every classroom.
3. Recommend closing a facility for the day when a fatality occurs (maybe longer).
4. Recommend DEL consider a more detailed report when a fatality occurs. The incident report should be completed by the child care provider with a timeline of events, making sure to include full legal names, description of child's condition/behavior, section for describing staff's responses, and a list of investigators assigned to it (law enforcement, witnesses, etc.).
5. Recommend DEL develop a written policy regarding complaints and the use of interpreters when interviewing individuals whose first language is not English.
6. Recommend the use of audio recording of interviews for critical incidents and fatalities.
7. Recommend centers have someone designated at each facility for all hours who has the authority and qualifications to make decisions.
8. Recommend a more detailed response process regarding grief support for parents as well as providers.
9. Recommend a special complaint unit to deal with critical incidents (anything DLR/CPS).
10. Recommend DEL gather all needed pieces of information before the Fatality Review Committee meets.
11. Recommend DEL is given the ability to get medical records (such as from the coroner and medical examiner).