



**STATE OF CONNECTICUT
OFFICE OF THE CHILD ADVOCATE**

FATALITY REVIEW INVESTIGATIVE REPORT

**THE DEATHS OF NINE CHILDREN
IN UNLICENSED AND LICENSED CHILD CARE
SETTINGS 2016-2017**

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EXECUTIVE SUMMARY

At the request of the General Assembly's Committee on Children, the Office of the Child Advocate ("OCA") conducted a review of the general practices of the Office of Early Childhood ("OEC") with respect to the review, suspension and license revocation of family child care homes. The Committee's request was made following the deaths that occurred in late 2016 of four infants who were enrolled in both licensed and illegal child care settings. While that review was underway, the OCA and the State Child Fatality Review Panel were apprised of five subsequent infant fatalities that occurred in home-based child care settings (both licensed and illegal child care). Therefore, the scope of the OCA's review was expanded to include these other children's death.

State law requires that all Child care settings, home or center-based, be licensed by the State to provide such services. The state's licensing statutes and regulations provide for 1) background checks; 2) professional development; 3) staffing requirements; 4) inspections; and 5) a framework for ensuring the health and safety of children. Relative care providers are not required to be licensed (example: a grandmother caring for grandchildren).

Between March 2016 and November 2017, there were a total of nine (9) recorded infant and toddler fatalities that occurred in separate non-relative home child care settings, both licensed and illegal. Six (6) of the nine (9) children who died in child care settings were being cared for in illegal child care settings. There were no reported deaths of children in licensed center-based child care settings. The manner of death for the nine (9) children (as determined by the Office of the Chief Medical Examiner) includes death from natural causes, accidental/unintentional injury, including fatalities associated with unsafe sleep environment and homicide/intentional injury.

In February 2018, OCA apprised the legislature that the nine deaths of children in child care settings during a two year period appears to be a marked increase in child care-based child fatalities. Both OCA and OEC were concerned that the decrease in enrollment in the Care 4 Kids Program, which was reopened in November 2017, might explain the uptick in child fatalities. OCA strongly recommended that lawmakers maintain and strengthen low-income families' access to high-quality licensed child care as a matter of public policy (a) to improve health and safety outcomes for young children, and (b) as a strategy to support child fatality prevention.

As OCA has reported in other child fatality reports, children under age three are most at risk for critical and fatal injuries. Children under the age of twelve months are at the greatest risk for preventable death from conditions associated with unsafe sleep environment.

Child care providers must be well-versed in infant care, hazards and risks presented by "unsafe sleep" environment for babies under twelve months of age, fall prevention, administration of medication to young children, and responding/supporting children's developmental and special health care needs. OCA is alarmed that six of these children died in illegal child care settings

In the OCA 2017 annual fatality report, death associated with unsafe sleep environment is the leading cause of preventable death of infants in the State.

During the course of its review, the OCA had frequent discussions with the OEC leadership. Commissioner Wilkinson remains committed to ensuring high quality care for infant and toddlers through its agency's efforts to continue revising its education and oversight framework for licensed and unlicensed child care settings. The following brief summary of OCA findings and recommendations (discussed in detail later in this Report), outline the importance of quality care for vulnerable infants and toddlers and the need to rely on safe, nurturing and caring child care settings.

The nine children who died in child care settings during 2016 and 2017 died in ways that are consistent with the general findings regarding child fatalities in Connecticut—death associated with unsafe sleep conditions, medication toxicity, blunt force trauma, and a range of natural but possibly preventable causes. OCA recommends continued strengthening of the state's public health campaign to prevent infant fatalities attributed to unsafe sleep, ingestion injuries, accidental injuries, and homicide.

The majority of children who died in child care setting were being cared for in unlicensed homes—a marked increase over previous periods of review. The OEC, in collaboration with state agencies such as OCA and DCF, should continue to examine data regarding utilizers of illegal child care and that lawmakers maintain and continue to strengthen low-income families' access to high-quality licensed infant-toddler child care.

The OEC has been working to improve safe sleep fatality prevention efforts. OEC should swiftly adopt new regulations which strengthen and clearly articulate appropriate standards for infant safe sleep practices.

One child died in a child care home whose provider had previously had the license to operate a child care revoked. OEC failed to ensure that the home ceased operating post revocation, despite policy requiring such follow up. In addition parents were not notified of the licensing action as required by policy. OCA recommends that OEC strengthen its internal quality oversight to ensure that licensing staff adhere to agency policies and practices regarding verification of ceased child care operations and parental notification of licensing action.

OCA found that while the OEC continues to strengthen its approach to data collection and incident reporting, the agency must ensure a statewide data-driven and accountability framework for the provision of high quality infant-toddler care and early childhood education.

The OEC does not have a method of correlating the severity of the regulatory violation with instances of harm to children enrolled in licensed facilities so as to better inform decision-making with regard to the continuum of corrective actions and child protective activities. OEC should consider implementing a classification system that is responsive to reliable information regarding the most prevalent risks of harm to children.

METHODOLOGY

The Office of the Child Advocate is an independent state oversight agency directed by state statute to investigate and publicly report on the efficacy of child-serving systems, review complaints of persons concerning the actions of any state or municipal agency providing services to children, and investigate unexplained and unexpected child fatalities and critical incidents involving a child.¹ The OCA was created in 1995 in response to the death of an infant involved with the Department of Children and Families.² The Child Advocate is a statutory member and current co-chair of the State Child Fatality Review Panel (CFRP). The OCA consulted with the CFRP regarding the development of this report and the issues contained herein. The OCA's investigation methodology for this report included the following:

- Review of records from the Office of the Chief Medical Examiner regarding the death of 9 infants and toddlers in child care settings, licensed and unlicensed, between March 2016 and November 2017.
- Review of law enforcement reports related to the above-referenced child fatalities.
- Review of child welfare records created by the Department of Children and Families regarding these child fatalities and any other pertinent child welfare records related to the licensed or unlicensed child care programs serving the child/ren.
- Review of records created by the Office of Early Childhood (OEC) regarding the child fatalities in child care programs and any other pertinent records related to the licensed or unlicensed child care programs, including information concerning inspection, licensing, suspension or revocation of the subject child care programs.
- Review of OEC policies, procedures, regulations and draft regulations regarding the oversight of licensed child care programs in Connecticut, including information regarding licensing, inspection, training/technical assistance, and corrective action.
- Review of state statutes concerning the licensure and oversight for child care programs and regulatory requirements for programs' licensing and operation.
- Review of national standards and best practices associated with the regulation and oversight of child care programs and facilities.
- Meetings and discussions with representatives from OEC.

INTRODUCTION AND TERMINOLOGY

In 2016 and 2017, three (3) children died in home-based child care programs licensed by the State's Office of Early Childhood. Six (6) children died in home-based, unlicensed child care settings. Unless covered by an explicit and narrow statutory licensing exemption, it is illegal to operate an unlicensed

¹ Conn. Gen. Stat. § 46a-13k *et seq.*

² The OCA was initially established after the homicide of a baby with an open child welfare case. The OCA has regularly monitored and reported on child deaths in Connecticut and has prepared and published numerous child death investigative reports for the purpose of informing the public regarding the causes of preventable child death and strategies for prevention.

Child care in Connecticut. There were no child deaths in 2016 or 2017 in center-based child care.³ This report examines the manner and circumstances of death for the nine children who died in licensed and unlicensed⁴ home-based child care settings in 2016 and 2017; and Connecticut’s system for preventing critical and fatal injuries to children in child care settings through oversight and data-driven support of licensed child care and increased access to licensed child care for low-income families.

TERMINOLOGY

Office of Early Childhood—The Office of Early Childhood (“OEC”) was first created in 2013 pursuant to Executive Order No. 35 to coordinate and improve the various early childhood programs and components in the state to create a cohesive high-quality early childhood system. The OEC and its statutory mission was thereafter legislatively established by Public Act 14-39. The OEC oversees a coordinated system of early childhood care, education and support. The OEC is organized into four divisions: (1) Early Care and Education; (2) Licensing; (3) Quality; and (4) Family Support Services.⁵ Prior to the creation of the OEC, licensing of child care was overseen by the Department of Public Health (“DPH”). Operative regulations for child care were drafted by the DPH. The OEC is in the process of drafting new regulations for child care.⁶ Licensing histories referenced in this report that include information from before 2013 incorporate oversight activities completed by the DPH.

Home-based licensed Child care—refers to a child care that is based in an individual home (outside of the child’s home) and that is regularly providing care to non-relative children for at least 3 hours per day.

Home-based unlicensed child care—refers to a child care that is based in an individual home (outside of the child’s home) and that is regularly providing care to unrelated children for at least 3 hours per day, but where the individual is not licensed by the Office of Early Childhood to provide such care. The operation of an unlicensed child care violates state law, and the OEC is authorized by law to seek the closure of such programs and associated civil penalties.

Note—Unlicensed (illegally operated) child care providers are distinguished from *relative* care providers who are not required to be licensed, and who may be eligible to receive Care 4 Kids subsidies to care for a child (example: a grandmother caring for grandchildren).

³ Referred to in statute as “child care centers.” Conn. Gen. Stat. § 19a-88(a)(2).

⁴ Illegal child care providers are individuals or entities operating unlicensed child care. Connecticut law requires all child care facilities/child care to be licensed by the Office of Early Childhood. Illegal child care providers are distinguished from *relative* care providers who are not required to be licensed in order to care for a child or be eligible to receive Care 4 Kids subsidies to care for a child (example: a grandmother caring for grandchildren). Additionally a nanny who is providing care for a child in the child’s own home does not have to be licensed by the state. Per statute, certain types of child care programs are exempt from licensing requirements such as a program “administered by a public school system” or “by a private school.” Additional license-exempt child-serving arrangements include certain classes (art/drama/music), library programs, sports activities, tutoring, informal relative arrangements, nationally-charted boys’ and girls’ clubs that are exclusively for school-age children; and certain religious education activities. Conn. Gen. Stat. § 19a-77.

⁵ Early Intervention programs have been combined into the Family Support division of the agency.

⁶ Draft Regulations promulgated by the Office of Early Childhood can be found on the agency’s website here: <https://surveyentrance.com/pub/oc/oec/Draft%20Regs%20Family%20with%20Watermark.pdf>.

BRIEF SUMMARY OF RELEVANT STATE LAW AND REGULATIONS REGARDING HOME-BASED CHILD CARE

A brief summary of OEC regulations pertaining to home-based child care, including the highlights of particular statutes and regulations pertaining to this child fatality review, is included below. The full text of OEC regulations and draft regulations can be found on the OEC website.⁷ The state has separate regulations for home-based and center-based child care programs. This summary covers regulations generally, and certain regulations which are applicable to *home-based child care* only.

Child care Programs Must Be Licensed By the OEC

All child care settings, home or center-based, unless otherwise legally exempt,⁸ are required to be licensed by the state. Licensing regulations address requirements regarding the conditions of the facility/setting, staffing ratios and background checks, training, and child safety and supervision.

Licensing and Inspection

Once a child care program is licensed, the OEC is required to “make an unannounced visit, inspection or investigation” of the child care “at least once every year.”⁹ The regulations mandate that the child care provider maintain a clean, safe and developmentally appropriate environment for the children in the child care. Regulations address, among other items, cleanliness, environment hazards and toxins, fire safety, weapon storage, safe play spaces, safe maintenance of poisonous substances, water safety, and first aid supplies.¹⁰

Capacity-General

State statute provides that a home-based child care provider may care for “not more than six children, including the provider’s own children not in school full time, where the children are cared for not less than three or more than twelve hours during a twenty-four hour period.”¹¹

Capacity-Infants and Toddlers

A provider “shall care for no more than two (2) children under the age of two (2) years at one time, *including his/ her own children.*”¹² If there is an assistant present, then the provider may care for up to six children under the age of two.¹³

⁷ Current OEC regulations can be found here: <http://www.ct.gov/oec/cwp/view.asp?a=4542&q=545996>.

⁸ *Supra* n. 4.

⁹ Conn. Gen. Stat. § 19a-87b(a); *see also* Conn. Gen. Stat. § 19a-82. Annual inspection has been required as of July 1, 2014.

¹⁰ Connecticut Regulations of Connecticut State Agencies § 19a-87b-9.

¹¹ Conn. Gen. Stat. § 19a-77(3). There are other provisions that apply to the care of additional children who are school-age. The focus of the OCA’s review was on family child care homes. However, its findings and recommendations may also be applicable in some instances to child care centers and group child care homes, which are also under the oversight of the OEC. Those facilities are defined as: (1) A “child care center” which offers or provides a program of supplementary care to more than twelve related or unrelated children outside their own homes on a regular basis; (2) A “group child care home” which offers or provides a program of supplementary care (A) to not less than seven or more than twelve related or unrelated children on a regular basis, or (B) that meets the definition of a family child care home except that it operates in a facility other than a private family home.

¹² Regulations of Connecticut State Agencies § 19a-87b-5.

¹³ *Id.*

Staffing Requirements and Training

All staff members must be approved by the OEC,¹⁴ and regulations require state and national background checks, including the state child abuse registry, and documentation regarding the physical health of the applicant and household members age sixteen or older. Unlike center-based child care, there are no current educational/degree requirements for directors/owner-operators or assistants of home-based child care programs, and there are no requirements for health/education/dental consultations to the program. Providers must be certified in basic first aid.

Child care providers who accept Care 4 Kids, a state and federally-funded subsidy for low and moderate income families to assist with the cost of child care, are required to complete orientation training and ongoing professional development, which training requirements have become more robust pursuant to recent changes in federal law. The state's Care 4 Kids flyer indicates that the orientation covers topics including First Aid, CPR, medication administration and "Health and Safety."

Infant Care-Supervision

Regulations provide that appropriate supervision of the children must be done by a "provider who is within effective sight or sound of the children."

Medication

A home-based Child care provider is not required to administer medications to children, but if they do so they must comply with all regulatory requirements, which provide that for anything other than non-prescription topical medications, the provider or responsible assistant must "first be trained by a physician, physician assistant, advanced practice registered nurse or registered nurse in the methods of administration medications and shall receive written approval from the trainer which indicates that the trainee has successfully completed a training program as required herein."¹⁵

Corrective Actions/Penalties for Licensing Violations

OEC regulations do not use a classification system to categorize violations in terms of severity or risk to children. Agency personnel may exercise discretion and judgment in making determinations about violations, re-inspections, and corrective actions. There are no specific timeframes for re-inspection and compliance within the agency regulations. There are no specific mandates for re-training of a provider or use of probationary status based on a certain type or number of violations.

Operation of Unlicensed Child care

The OEC may seek civil penalties against an unlicensed child care, and through the Office of the Attorney General, the OEC may seek an injunction against further operation of the child care.

Notice to Parents/Public

Providers are required to notify parents of any proposed summary suspension and in any other case when so ordered by the Commissioner of OEC.

¹⁴ See Conn. Gen. Stat. § 19a-87b(b).

¹⁵ *Id.* For nonprescription topical medications such as diaper changing ointments or teething medication, regulations require written permission from the parent prior to the provider administering such medications.

The OEC provides the public with information concerning each child care’s license status through the State’s e-License site.¹⁶ E-license includes information regarding substantiated findings of abuse or neglect occurring with licensed child care programs as well as dates of inspection, complaint history, and quality enhancement history (disciplinary actions).¹⁷ OEC also provides information to consumers and providers through its Help Desk and through Child Care 211.¹⁸

Infant Care—Safe Sleep

Regulations (for both center-based and home-based child care) require that providers ensure appropriate physical and developmental care for infants and toddlers, including that children are afforded “proper rest,” through provision of a setting that is “comfortable, clean, and safe.”¹⁹ Current regulations for home-based child care programs have not contained specific directives regarding adherence to recognized “safe sleep” practices, such as the guidelines promulgated by the American Academy of Pediatrics. OEC draft regulations seek to address this critical deficiency. OEC has recently implemented a new safe-sleep/no blankets policy, effective May 2018, which policy was developed in consultation with the state’s Child Fatality Review Panel.²⁰

What Is Safe Sleep For Infants?

Babies Should Always Be Placed On their Backs to Sleep--with a firm surface like a crib, bassinet, or portable crib that meets current safety standards

Make Sure There are No Soft or Loose Objects Placed with the Baby--cover the mattress with a fitted sheet. Do not put blankets or pillows between the mattress and the fitted sheet. Pillows, quilts, comforters, sheepskins, bumper pads and toys can be dangerous.

Same Room to Sleep; Not the Same Bed--babies who sleep in the same bed as their parents are at risk of sudden unexplained infant death, suffocation or strangulation.

Keep Your Baby Away From Smokers.

Do Not Let Your Baby Get Too Hot--keep the room where your baby sleeps at a comfortable temperature and in general, dress your baby in no more than one extra layer than you would wear.

American Academy of Pediatrics

Three Child Fatalities in Licensed Child Care Settings

Baby B.—Manner of Death: Homicide/Blunt Force Injuries

On July 12, 2016, two month old Baby B., a child enrolled in the home-based licensed child care of Nydia Carrillo-Maldonado,²¹ died from blunt force injuries. Investigations were conducted by DCF,

¹⁶ <https://www.elicense.ct.gov/>.

¹⁷ <https://www.elicense.ct.gov/Lookup/LicenseLookup.aspx>.

¹⁸ According to OEC, its Help Desk receives approximately 8,840 calls per year and the majority of these calls are from providers or aspiring providers.

¹⁹ Connecticut Regulations of Connecticut State Agencies § 19a-87b-6.

²⁰ The OCA is a statutory member and current co-chair of the state’s Child Fatality Review Panel, established pursuant to Conn. Gen. Stat. § 46a-13/.

²¹ This report will identify child care providers who were criminally charged in connection with the child’s death.

OEC, and the Stamford Police Department. Ms. Carrillo-Maldonado was subsequently arrested and charged with Manslaughter and Risk of Injury to a Minor in connection with Baby B.'s death.²² DCF determined that there was sufficient evidence to substantiate allegations of physical abuse/neglect as to Ms. Carrillo-Maldonado, and DCF placed her on the state's child abuse registry due to the abuse or neglect resulting in the death of a child.²³ Ms. Carrillo-Maldonado voluntarily surrendered her license to the OEC on July 25, 2016, and the OEC "withdrew the statement of [administrative] charges" against her.

The Carrillo-Maldonado's child care was previously inspected on multiple occasions with inspections resulting in mandatory corrective action plans. Beginning in February of 2015, at the initial inspection conducted by the OEC to determine whether a license would be granted, the OEC identified deficiencies that included: safety (bathroom floor was "very slippery" and there were "toxins" that were accessible to the children), safe exits (three (3) areas were missing gates/locks), physical environment – protection from pets (there was no rabies certificate for the family pet) and meeting children's physical needs (mattress in crib was not tight fitting and not appropriate for child care).

Carillo-Maldonado was required to correct the deficiencies prior to the issuance of a license. Subsequent inspections included violations for various physical environment concerns and one missing background check documentation regarding a staff member.²⁴

Multiple inspections were conducted by OEC in July 2016 following the death of Baby B. These inspections and subsequent investigation activities led to citations against the child care for multiple violations that included: expired first aid training, missing enrollment forms, missing health records and permissions from parent²⁵ (including for Baby B.); child protection violations; good judgment

²² Charges remain pending against Ms. Carrillo-Maldonado.

²³ Pursuant to Conn. Gen. Stat. § 17a-101k-1, a "registry finding" means the determination by the [DCF] Commissioner or the Commissioner's designee, based on a standard of reasonable cause, that a person who has been substantiated as an individual responsible for abuse or neglect of a child poses a risk to the health, safety or well-being of children." The "registry" is a "confidential data file maintained as part of the department's computerized database, of persons who have been substantiated as individuals responsible for an act or acts of child abuse or neglect and for whom the commissioner has made a determination, based upon a standard of reasonable cause, that the individual poses a risk to the health, safety or well-being of children." Gen. Stat. § 17a-101k-3 provides that "to enter the name of an individual responsible on the central registry, the commissioner, or the commissioner's designee, shall make a determination that: (1) child abuse or neglect has occurred; (2) there is an identifiable individual responsible for abuse or neglect; (3) the individual responsible poses a risk to the health, safety or well-being of children; and (4) the name of the individual responsible should be listed on the central registry, provided that the individual's name shall not actually appear on the registry until the exhaustion or waiver of all available administrative appeals." State statute outlines in detail the criteria by which DCF must or may determine that an individual be placed on the Central Registry.

²⁴ Additional inspections were conducted in March, 2015; December, 2015; and May, 2016. The March, 2015 inspection noted more violations and specifically cited physical environment – freedom from hazards; missing background check for staff member; uncovered electrical outlets; unsafe conditions outside due to construction materials; insufficient lighting; trash cans that were uncovered and again cited the lack of an updated rabies certificate. The last inspection conducted by the OEC prior to the death of Baby B. was in May of 2016, in which the OEC cited Ms. Carillo-Maldonado for additional violations, including physical environment – freedom from hazards due to construction equipment left accessible to children in the back yard. The equipment was not covered and presented a safety hazard to children.

²⁵ "Written permissions" means, pursuant to Regulation §19a-87b-10(b)(3)(A-D): "the provider shall have on file and shall keep updated the parent's written permission and instructions specifying, but not limited to, the

about supervision and safety and full attention and supervision; the latter violations all related to the death of Baby B.

DCF's investigation included the family's concern that Baby B.'s older brother, 16 months old at the time of the baby's death, had previously gone home from the child care with unexplained bruises, all of which were questioned by the parents at the time and explanations given by the child care provider. After Baby B.'s death, two of the bruising incidents were described to medical professionals and characterized by the same professionals as suspicious for child abuse: e.g., bruising on the little boy's groin area, and bruising on his ear. The incidents had not been reported by the provider to DCF or the OEC, but were learned of by investigators after Baby B.'s death.

Neither the OEC Inspection Manual nor the agency's regulations include a framework for formally classifying regulatory violations by severity/risk levels.

Some states utilize risk/severity classification systems to guide follow-up and corrective action, including re-training activities and program re-inspections.

OCA recommends that OEC review the need to develop a risk/safety classification system to support critical injury prevention in licensed child care.

Baby C.—Manner of Death: Undetermined/Sudden Unexplained Infant Death

On October 5, 2016, Baby C., a three-month old child enrolled in a home-based licensed child care, died while asleep in an unsafe sleeping environment in the child care. DCF investigation at the time of baby C.'s death expressly found:

- Numerous immediate child safety hazards that could pose harm to a child at the child care.
- Pillows and blankets in the pack-n-plays.
- Fire extinguisher on the ground that could have easily fallen on the children.
- No gate at the bottom of the stairs leading to the residence.
- Stairs had debris that could have posed a choking hazard to the children.
- Foul odor that permeated throughout the home.
- The operator was "*alone with five children under the age of 2.5 years old at the time of [baby's] death.*"²⁶

Investigations by DCF and OEC following the baby's death found that the child care provider reportedly put baby C. down on her stomach for her nap, swaddled from the waist down. During

following: (A) Any persons permitted to remove the child from the child care home on behalf of the parent. (B) Emergency health care for the child, including information about the child's dentist, physician or other primary health care provider, and adults to be contacted if the parent cannot be reached. (C) Transportation for children leaving the home as part of the child care program. (D) The conditions under which the parent will allow swimming when recreational swimming is part of the family child care program.

²⁶ All findings are quoted from the DCF investigation record.

Staffing ratio/capacity

OEC regulations require that a provider care for no more than two children under the age of two years old unless there is an approved staff present.

interviews following baby C.'s death, the provider stated that she had put the baby down for a nap and when she checked on her later, the baby was not breathing. DCF found that the provider allowed her assistant to leave the daycare around 1:15 p.m., despite having been previously cited by OEC in March 2016 for being overcapacity without approved staff to help care for the children.²⁷

At the time of baby C.'s death in October, the provider was again alone, this time with five infants and toddlers. DCF substantiated the child care provider for physical neglect due to concerns about her failure to employ safe sleep practices and failure to adequately supervise the children (due to being over-capacity as a licensed child care), and placed her on the state's Central Registry due to the neglect resulting in the death of a child. On November 1, 2016, the provider signed a Voluntary Surrender of her child care license and therefore no revocation hearing was held by the OEC.²⁸

OEC, and previous to OEC, the Department of Public Health (DPH), had conducted numerous inspections of the child care since it first began operation in May of 2002 and which resulted in multiple Corrective Action Plans. Inspections of the child care between 2010 and 2016, made findings as to Physical Environment violations;²⁹ Responsibilities of Provider & Substitute violations;³⁰ Qualifications of Provider & Health;³¹ Meeting Children's Physical Needs violations³² and Capacity – Infant/Toddler Restriction violation.³³

After Baby C.'s death in October 2016, the OEC's inspection and investigation identified numerous licensing violations, including a violation for exceeding the capacity for infants and toddlers, failing to demonstrate good judgment about supervision and safety, failing to maintain licensed capacity, failing

²⁷ The March 2016 inspection was a full unannounced inspection, done at 12:50 p.m. There is no mention in that inspection report of any concerns about safe sleep practices.

²⁸ Beginning in May of 2002, at the initial inspection conducted by the DPH, the provider was cited for the following violations: Physical Environment – Absence of Poisonous Substance (linen closet had detergents that were accessible to children); Physical Environment – Fire Safety (door fasteners were deemed not safe); and Physical Environment – Adequate and Safe Water (the pool fence was not high enough). By June of 2002, the provider had corrected the May 2002 violations and was in complete compliance with all state regulations. There were no inspections conducted by the DPH between June 2002 and December of 2005. (During this period, annual inspections were not required.) In December of 2005, the DPH conducted a full unannounced inspection and cited the family child care home for the following violations: Infant/Toddler Restriction (caring for more than two (2) children under the age of two (2) at one time, without an approved assistant present – she had 5 children under the age of 2); Qualifications of the Provider - Personal Qualities (failing to “demonstrate good judgment about the supervision and safety for children when you failed to maintain your licensed capacity”); and Licensed Capacity (failing to maintain family child care home within the licensed capacity). Those violations were corrected by February of 2006.

The provider was cited for additional violations in October of 2007, including Health violation (missing medical form for provider) and Physical Environment - Fire Safety, Adequate and Safe Water violations (safe door fastener, pool gate and written evacuation plan).

²⁹ July, 2010; December 2012; June 2015; August 2015; November 2015; January 2016 March 2016; May 2016.

³⁰ July 2010; December 2012; November 2015.

³¹ December 2012; March 2016.

³² June 2015. This violation involved two Pack-n-Plays that had snug fitting mattresses.

³³ March 2016.

to use “good judgment when placing [Baby C.] on her belly/side to sleep,” failing to comply with the OEC’s “proper rest” regulation, and missing forms for incidents and enrollment.

After the provider voluntarily surrendered her child care license in November of 2016, the OEC conducted follow-up inspections on November 15th and December 23rd to confirm that she was not continuing to operate a child care. The OEC found no evidence of continued child care operation.

**Baby C.M.—Manner of Death:
Undetermined/Sudden Unexplained
Infant Death**

On January 23, 2017, Baby C.M., a four month old baby boy, died in a home-based licensed child care. At nap time, the baby was put on his side in a pack-n-play with a blanket over him. The provider reported that she went to check on him more than two hours later as he was still sleeping. The provider further reported to police that when she picked the baby up “he was limp,” and he “had a purple discoloration to one side of his face.” The provider initiated CPR and called 911. There were no other adults in the home. There were three other children in the home being cared for by the provider--a 4 year old and two 3-year-old children.

The provider reported to DCF that the baby’s side-sleeping position was the result of her own judgment and experience with children and was not based on a particular recommendation from the baby’s parents. The provider acknowledged to DCF that she was aware of safe sleep recommendations that infants should be placed on their back in a sleep space with no blankets or other items; however the provider conceded that she still placed the baby in the pack-n-play on his side, with a blanket, later stating that not all babies sleep well on their backs. Records also indicate that during a July 2016 inspection, the OEC gave [the provider] a safe sleeping brochure, which she signed for, and the OEC discussed safe sleep practices with her.³⁴

Following the child’s untimely death, DCF did not substantiate the provider for abuse or neglect, noting that there did not appear to be concerns about the provider’s care for the children. However DCF did note its concern that “[t]here is a possibility that unsafe sleep conditions played a role in the cause of death.” DCF does not currently have a policy articulating when the failure of a professional caregiver to adhere to safe sleep guidelines or requirements constitutes abuse or neglect in the context of a critical or fatal injury to a child.

**OEC Guidance to Providers Addresses Safe
Sleep Standards**

After Baby C.’s death, the child care provider was cited by OEC for violating the regulations’ “Proper Rest” standard, which standard, as currently articulated in OEC regulations, *does not* specifically speak to contemporary safe sleep standards. OEC does, however, give child care providers information regarding safe sleep and OEC inspectors reinforce these expectations during site visits. OEC is currently drafting new regulations that specifically include “safe sleep” requirements for all child care programs. OEC has recently issued directives for providers articulating clear expectations for adherence to nationally-promulgated “safe sleep” guidelines.

³⁴ The OEC inspection form provides contemporaneous documentation of the safe sleep discussion and the provision of safe sleep guidelines to the provider.

DCF indicated to OCA that certain cases involving unsafe sleep practices may lead to a substantiation for neglect, on a case by case basis.³⁵ The OEC had conducted numerous inspections of this child care over the years and cited it for what the investigator later characterized as minor violations.

At a July 2016 inspection, the OEC noted that safe sleep and proper supervision was specifically

Safe Sleep Not Discussed with Parents by Provider

During interviews, multiple parents whose children were served in the child care along with C.M. told DCF that they did not specifically discuss their babies' sleep positioning with the child care provider, but assumed that the provider "knew" the safest position to place babies to sleep.

Experts recommend that safe sleep information be disseminated to all child care providers, consumers, and that discussions be had about the importance of safe sleep practices and obstacles to implementing such practices consistently.

discussed with the provider and OEC gave her written information regarding safe sleep. The inspection was conducted at 11:20 a.m., and there was no documentation that the provider was engaging in unsafe sleep practices at the time of the inspection. The provider was cited at the July 2016 inspection for deficient Incident Logs and missing Health, Enrollment, and Immunization records for certain children in her care.³⁶

Six Child Fatalities in Unlicensed Home-Based Child Care March 2016 through October 2017

It is illegal to operate an unlicensed child care in the state of Connecticut unless license exempt per statute.³⁷

Baby A.—Manner of Death: Homicide/Acute Diphenhydramine Intoxication.

On March 22, 2016, four month old A., a baby boy, died of diphenhydramine³⁸ toxicity in the unlicensed home-based child care of Carol Cardillo. Ms. Cardillo had been operating the unlicensed child care in her home for over eleven years and she employed two assistants to help care for the children. Investigation found that at the time of Baby A.'s death there were eight other children in the child care ranging from 4 months old to 4 years old. Neither the provider nor the assistants were CPR-certified. Law enforcement investigation revealed that all of the parents were aware the child care was not licensed.

³⁵ In the case discussed above of baby C., DCF substantiated due to concerns about unsafe sleep conditions and neglectful supervision due to the provider's "over-capacity" status and other observed concerns.

³⁶ The provider's license was suspended following an inspection in June 2017 for reasons unrelated to the fatality that occurred in January of 2017. She was cited for refusing to allow an investigator from the OEC to do an inspection because she claimed to have no children on that particular day and had to leave for a family event. The OEC considered that refusal to be grounds for the revocation of her license. The provider successfully fought the revocation, and she continues to operate a home-based child care.

³⁷ *Supra* n. 4.

³⁸ Diphenhydramine is an antihistamine--the active ingredient in medicines such as Benadryl.

Per DCF investigation records, the parents reported that Baby A. was a “fussy baby,” and that his fussiness was discussed with the child care provider. At home, Baby A. would reportedly nap “no longer than 45 minutes during the day” and only if conditions were “perfect,” i.e. no light, sleep machine on, and complete quiet. Baby A.’s father reported that only mom could put the baby down for a nap. The father stated that the child care provider had a “magic touch” because Baby A. would “nap for her sometimes for an hour and a half,” which was much longer than the baby would nap at home with his parents.

After the baby’s death, OCME found a high dose of diphenhydramine in the baby’s blood, a dose significantly greater than the therapeutic dose for an adult. Baby A.’s death was classified by OCME as a homicide. The child care provider and her assistants all denied that any child would be administered Benadryl in the home. However police discovered that the provider had purchased 90 bottles of generic-label Benadryl over a three-year period and had last purchased a bottle the week prior to baby A.’s death.

DCF substantiated the child care provider for neglect, and placed her on the Central Registry. Ms. Cardillo was criminally charged and she pleaded no-contest to second-degree manslaughter and was sentenced to 30 months in prison, followed by five years’ probation. The OEC issued a civil penalty in the amount of \$204,500 for the illegal operation of an unlicensed child care. Ms. Cardillo requested a hearing to challenge the civil penalty. The final day of the hearing was May 11, 2018. The hearing officer proposed, and the OEC Commissioner agreed to, a final civil penalty of \$87,700.

Licensed Child Care Not Permitted to Administer Medication Without Proper Training

Per Connecticut law, a licensed home-based child care provider is not required to administer medications to children, but if they do so they must comply with all regulatory requirements, which provide that, for anything other than non-prescription topical medications, the provider or approved substitute must “first be trained by a physician, physician assistant, advanced practice registered nurse or registered nurse in the methods of administration medications and shall receive written approval from the trainer which indicates that the trainee has successfully completed a training program as required herein.”

Baby K.—Manner of Death: Natural/Viral Myocarditis with Influenza A Infection

On July 14, 2016, nine month old K., a baby girl, stopped breathing during her sleep in an unlicensed home-based child care. The child care’s license had been revoked by OEC the year before for multiple regulatory violations, including being over-capacity and failing to supervise the children. OCME found that baby K. died from a viral infection. Baby K. had been placed to sleep in a pack-n-play in the child care provider’s third floor bedroom, with one blanket beneath her and another blanket laid on top of her.³⁹ The provider reported that she put the baby down for a nap, and that when she went to check on her, the fleece blanket was wrapped tightly around Baby K., and she was not breathing.

The provider called 911 and started CPR. The baby was pronounced dead at the hospital. Investigation revealed that there were no monitors in the baby’s room. At the time of Baby K’s death, there were eight children in the home, including the provider’s three children. The ages of the children ranged from 8 months old to 10 years old.

³⁹ An OEC record of a March 31 2015 follow-up inspection documented that the OEC discussed safe sleep practices with the provider.

Safe Sleep Advisement

The unlicensed child care provider denied that any licensing or child protective services worker had previously counseled her or trained her regarding safe sleep practices for infants under age 1.

DCF and OEC noted that the home's license had previously been revoked due to concerns about the provider's failure to adhere to licensing capacity and her failure to adequately supervise the children. During the previous DCF investigation the provider "had no idea that an 18 month old child had gone outside; it was his mother who found him outside with [the provider's] two dogs"⁴⁰ and the provider was found to have 13 children in her care (including 3 of her own children). The provider was cited for a variety of violations and her license was revoked.⁴¹

Police and DCF investigation into the death of Baby K. found that, despite the revocation of her license, the provider continued operation of her daycare. OEC records indicated that it had conducted a follow-up inspection on October 5, 2015 to ensure that the provider was not continuing to operate a child care home. The OEC investigator made the following statement:

"Observed no children/sign of child care activities. Provider appeared not to be home at time of visit. When I rang doorbell or knocked on door several times." There was no further follow-up or contact by the OEC concerning whether the provider was continuing to operate her child care until the death of Baby K.

The baby's family reported to investigators that they were family friends with the child care provider and the families often spent time together.

⁴⁰ September 2015.

⁴¹ Prior to the license revocation in 2015, an OEC Investigation Inspection followed by several Follow-up Inspections that were all conducted in June of 2015 included the following findings:

Qualifications of the Provider - Personal Qualities - 19a-87b-6(e) & 19a-87b-10(h)

"Licensee was unaware that a toddler walked out of the child care home and was found unsupervised in the yard by his parent . . . three children were observed through a window on the first floor unsupervised with the Licensee was downstairs with other children.

Qualifications of Staff & Personal Qualities - 19a-87b-8 and 19a-87b-6(e)

"Licensee allowed her sister, an unapproved staff member, to supervise several children downstairs . . . allowed her sister to remove two child care children from the premise without written permission from the parent."

Registered Capacity and Maintaining Compliance with Regulations & Personal Qualities - 19a-87b-10(a) and 19a-87b-6(e)

"There were 14 present which is 5 children over the licensed capacity" and on another occasion "2 children were present which is 3 children over the licensed capacity."

Physical Environment - Absence of Poisonous Substances - 19a-87b-9(c)

"accessible alcohol in the family room, accessible cleaning supplies, sunblock, and Pledge in the kitchen, and/or accessible bug spray and Febreze [sic] on the downstairs cubbies"

Electrical Safety - 19a-87b-9(d)(3)

"Uncovered and accessible electrical outlets in the living room and playroom."

Physical Environment - Freedom from Hazards - 19a-87b-9(b)

"Large pieces of exercise equipment were accessible to children"

Safe Exits - 19a-87b-9(d)(4)(D)

"The top of one staircase and/or bottom of another staircase were unprotected."

Maintaining Records on Children - 19a-87b-10(b)(3)(A)

"No authorized release permission for the Licensee sister to remove child care children from the premises."

The child’s mother stated that she believed the home was licensed, and that the provider had “told her there was an investigation [the year before] because a parent said there was a child alone outside, but mother thought it was dropped and she did not hear anything more about it.” OEC records received by OCA did not indicate that the OEC contacted parents about the license revocation.⁴² The provider reported to investigators that she informed all of the parents of the children she was caring for that her license was revoked, but that most of parents are family friends. She also denied that the work she was doing could be characterized as running a child care, but she acknowledged that she “does charge money for caring for the children.” She stated that Baby K’s parents were aware that her license was revoked. But at least two other families told DCF investigators that they did not know that the provider’s license had been revoked.

Following its investigation into the death of Baby K, DCF substantiated the child care provider for physical neglect. She was also placed on the Central Registry. No criminal charges have been filed at this time. OEC sought a civil penalty and the provider was found liable for a penalty in the amount of civil penalty of \$16,200.

**Baby J.—Manner of Death:
Natural/Sudden Unexplained Infant
Death**

On June 29, 2017, J., a two month old baby girl, died after being found unresponsive and not breathing in the home of her unlicensed child care provider. The provider stated that she had placed the baby on her back in the bassinet in a separate room, but when the provider went to check on her, reportedly 30 minutes later, the baby was non-responsive. The provider started CPR and called 911. Emergency personnel performed CPR upon arrival, but baby J. did not survive.

At the time of Baby J.’s death, the provider was caring for eight unrelated children, seven of whom were under the age of 3.

The baby’s parents stated that they did not know the home was unlicensed as they had seen children coming and going from the home “for years.” The mother and the provider were neighbors, and the mother asked the provider to care for her baby as she had recently started school to be a nursing

**OEC Policy for Child care Homes that
Have Ceased Operations**

The OEC Licensing Policy and Procedures Manual (latest version dated Oct. 2017) provides that OEC staff must conduct a follow-up visit/s to “verify that child care operation has ceased in situations when providers/operators have had their license summarily suspended or revoked, voluntarily surrendered their license or allowed their license to lapse.”

The policy provides that “if no adult is present, staff shall make at least *two more attempted visits* to verify operation has remained ceased. All attempted follow-up visits shall be documented on a supplemental inspection form.” In this case, there was a follow-up visit on October 5, 2015, which was not able to verify ceased care. No additional visits are documented. Records received by OCA do not include information as to whether the OEC notified the consumers of the child care about the license revocation.

OEC informed OCA that in the wake of Baby K.’s death, the agency developed the new policy for verifying “ceased care,” which policy includes clear directives regarding site visits and which requires multiple visits in certain cases.

⁴² OEC Guidelines require that “parent letters following summary suspensions, revocations and voluntarily surrenders are sent out by the Legal Division.” See OEC Guidelines for Verifying Ceased Care.

assistant. She paid the provider \$25 per day. The provider told DCF that she only knew baby J.'s first name and she did not have the mother's phone number or know the baby's date of birth because the baby was new to the daycare. Other families utilizing the provider's child care told investigators that they knew the home was not licensed but that they had no concerns about the provider's care for their children. DCF did not substantiate the provider for abuse or neglect.

Baby D.—Manner of Death: Natural/Respiratory Complications of Reactive Airway Disease Associated With Multiple Food Allergies

On October 5, 2017, fifteen month old Baby D. died after developing respiratory distress in the home of his unlicensed home-based child care provider. Baby D. had reportedly been cranky and not himself in the days prior to his death. He was new to the daycare, and had been previously cared for by his uncle while his mother worked. When the uncle obtained a new job, Baby D.'s mother needed to find alternate care. She met the child care provider through a mutual friend. The mother could not tell investigators what the provider's last name was, but she stated that the provider was "recommended" and that she had four other children in her care during the day. The family paid the child care provider \$60 per week and described her as a "Very nice person with a clean house."

Records indicate that Baby D. had allergies and respiratory issues, including a history of asthma, and that he was "dependent" on an inhaler and a nebulizer machine, as needed. He was prescribed an Epi-pen but it was not clear that this prescription had ever been filled.

DCF's investigation revealed that the provider had called the mother several times during the day, apparently to convey concerns about the baby's condition, but mother's job did not allow her to have a phone with her so she did not retrieve any calls until the late afternoon. The babysitter did not seek medical attention for the child. After the mother retrieved the calls, she rushed to pick the child up, and along with the child's uncle, they brought Baby D. to the hospital. The babysitter told DCF that she had not sought medical help for the child and that she "did not 'dare' call 911 because they ask about the 'mama y papa'."

Baby D.'s mother reported that the provider was aware of the baby's allergies and asthma and that she had "educated" the provider on how to give him medication as needed, such as his inhaler. However, the provider's family described the adult provider to DCF as having "undiagnosed autism," though they stated that she did not care for the children by herself, but was assisted by another family member. The self-identified assistant was described in DCF records as "unable to read or write." The provider and assistant stated that they did not know that the child had asthma, never saw any medications, and did not know that the child had allergies.

DCF substantiated the unlicensed child care provider and placed her on the Central Registry due to her failure to timely seek medical attention for the baby. DCF also substantiated Baby D.'s mother for entrusting a caregiver that was not licensed to care for the baby, despite the fact that the child "required special care due to his asthma and allergies," and because the mother did not have the appropriate medication for the baby.

Baby A.—Manner of Death: Accident/Blunt Head Trauma

On October 7, 2017, A., a twenty-month old little girl, died after sustaining a critical head injury in the home of her unlicensed caregiver. Police reported to DCF that the child had been dropped off at the provider's home two days earlier. The child and her 3-year-old sibling were cared for by the provider (the daughter of a family friend) from Monday through Friday (including nights) due to the parents' work schedule. DCF noted that the arrangement was unusual but that "the family appears to be low income with minimal resources." The children's mother worked from 6:30 a.m. to 8 p.m. four to five days per week. The family paid the provider \$100 every other week. The provider had previously completed a Care 4 Kids training but had never completed the process to become a licensed child care provider.

The provider reported to police that that the little girl had been "playing in the living room and she grabbed a blanket and was playing on the fourth step of the stairs," when the child fell down the steps and was seriously injured. There were no safety gates in the home. The provider contacted the mother who called 911 while the provider tried to keep the child awake. The provider later stated that she did not know how to call 911. The child was rushed to the hospital by emergency responders where she succumbed to severe brain injuries. The OCME found that the child died from complications of blunt head trauma and that the manner of death was Accidental. DCF substantiated the provider for physical neglect as she "failed to provide reasonable and proper supervision of [the child] given her age and cognitive abilities" and for failing to "timely obtain necessary medical treatment following [the child's] fall." DCF also placed the provider on the Central Registry due to the severity of the incident and the neglect resulting in the death of a child.

Following the OEC's investigation, it concluded that because Baby A. was being cared for in a child care setting for six (6) days a week (including nights) with her siblings, that technically the child care setting did not meet the statutory definition of a "family child care home" as described in Conn. Gen. Stat. § 19a-77(a)(3) and therefore was not required to be licensed.

Baby M.—Manner of Death: Natural/Acute Bronchopneumonia

On October 20, 2017, three month old Baby M. was found unresponsive on an adult bed of his unlicensed home-based child care provider. The provider identified herself to police and DCF as a "baby sitter" and not a child care provider, though at the time of Baby M.'s death he was one of six children being cared for by the provider. The provider reported that on the day he died, Baby M. was fussy in his "chair" so she placed him on his stomach on the bed with his head turned to the side.

When Baby M. died, he was one of six children under the age of 3 in the provider's care. Baby M.'s father told DCF that he was unaware that there were that many children in the child care.

When she checked on him, reportedly ten minutes later, the baby was non-responsive. OEC's investigator reported that it had previously shut down an unlicensed child care run by the provider's mother. DCF did not substantiate allegations of physical neglect by the provider as there was not "sufficient evidence to proof [sic] that Baby M.'s death was correlated with the care that [the child

care] provided to him.” The OCME found that Baby M. died from sepsis and acute bronchopneumonia.

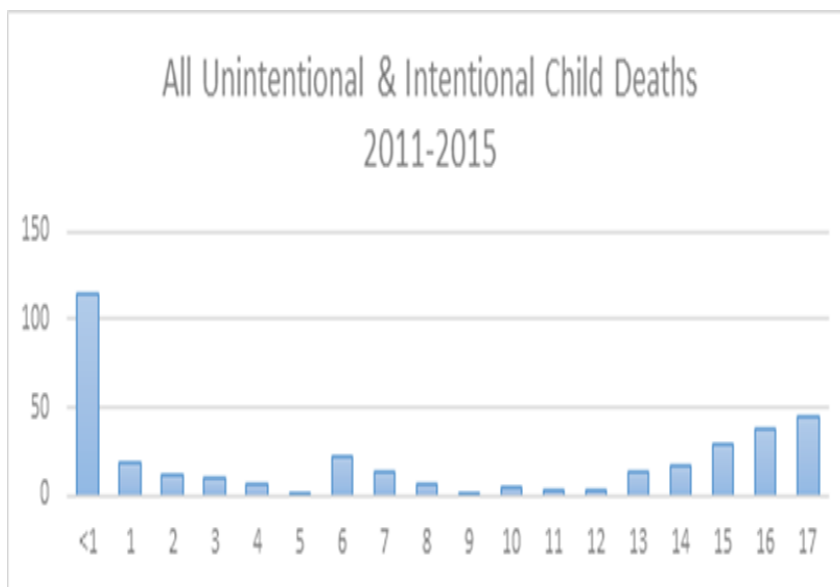
DISCUSSION OF INFANT-TODDLER FATALITY TRENDS IN THE STATE

The purpose of OCA’s review is to examine the circumstances leading to the death of these nine children and make recommendations regarding the prevention of child fatalities in child care settings. Accordingly, OCA examined the licensing framework for child care programs, the manner of death for the nine children as well as the most prevalent causes of death for infants and toddlers in the state.

Infants Are At Highest Risk for Preventable Death

From the OCA/CFRP’s most recent Five Year Child Fatality Report regarding child fatalities (0-17) that occurred in Connecticut between 2011 and 2015:

367 children [from 2011-15] died from unintentional and intentional injuries in Connecticut. The vast majority of those children were under the age of 1. Infants younger than 12 months of age have the highest risk for premature death, more so than at any other time during childhood and adolescence. The graph below depicts all unintentional and intentional injuries to children, birth through 17, in the 5 year period reviewed.⁴³



⁴³ See Office of the Child Advocate/Connecticut Child Fatality Review Panel: Examination of Child Fatalities, A Five Year Review 2011-2015. Found on the web at: http://www.ct.gov/oca/lib/oca/Final_Five_Year_Fatality_Report_2011-2015.pdf, at 5.

Death Associated with Unsafe Sleep Conditions Is the Leading Cause of Preventable Infant Death in Connecticut

A Public Health Alert published by the OCA and the CFRP in April 2014 found:

[t]he number of Connecticut infants who died between 2001 and 2013 where unsafe sleep conditions were present was almost three times the number of infants who died from child abuse. OCA and CFRP found that “[infants] in Connecticut were more likely to die from unsafe sleeping conditions than from child abuse, car accidents, choking, drowning, falls, or any other source of accidental injury.”⁴⁴

In Connecticut, deaths of infants in unsafe sleep conditions are classified, depending on scene investigation, as either Accidental (due to positional asphyxia) or as Undetermined. For the most recent 5 year period studied (2011-15), there were 97 infant deaths classified as either Undetermined or Accidental, with the vast majority of fatality investigations revealing the presence of modifiable unsafe sleep factors.

While a generation ago, infant deaths might have been labeled “crib death” and attributed to unexplained phenomenon, advancements in research and death scene investigation have led to a greater understanding of the environmental factors that contribute to “Undetermined” and sudden infant death. Investigations often reveal that many of these babies whose deaths were previously deemed inexplicable had actually been placed in sleep environments or in a sleep position that research has since determined to be harmful (e.g., sleeping with blankets or pillows in a crib).

As a result of the greater understanding of what leads to the unexpected death of infants during sleep, public health organizations around the country took steps to ensure robust dissemination of information regarding “safe sleep” to parents and caregivers. Campaigns such as the national “Back to Sleep” campaign were successful in *reducing* the number of preventable infant deaths, though reductions have plateaued in recent years. Today, infant deaths with correlative unsafe sleep findings persist as many states’ (including Connecticut) leading cause of preventable death of healthy babies.⁴⁵

In 2015 Connecticut passed Public Act 15-39 requiring hospitals to provide the parent/s or the legal guardian of a newborn infant with written informational materials containing the American Academy

⁴⁴ See Public Health Alert of the Office of the Child Advocate and the Connecticut Child Fatality Review Panel, April 7, 2014. Found on the web at:

http://www.ct.gov/oca/lib/oca/PublicHealthAlert_Safe_SleepApr_7_FINAL_docx_%282%29.pdf.

⁴⁵ “SIDS/SUID [Sudden Infant Death Syndrome/Sudden Unexplained Infant Death] remains the leading cause of death for infants between one month and one year of age... The majority of these suffocations happen to infants in unsafe sleeping environments. They suffocate when another person lays over them or when they smother in bedding or furniture.” Fact Sheet developed by the National Center for Fatality Review and Prevention, citing data from the National Center on Health Statistics. Fact sheet found on the web at <https://www.ncfrp.org/reporting/sidssuid/>.

of Pediatrics' recommendations concerning safe sleep practices.⁴⁶ Given what is known about the leading cause of preventable infant death in Connecticut and the importance of sharing information with caregivers as part of a comprehensive fatality prevention strategy, it is imperative that parents and caregivers have access to the latest information and clear messaging regarding safe sleep guidelines. It is equally imperative that child care providers are trained and supported to adhere to safe sleep guidelines, and that regulatory requirements for licensed child care contain clear requirements to ensure safe infant sleeping conditions and that all licensing inspections include close attention to these requirements. Finally, low-income families should have access to the state's network of trained and licensed child care providers to help ensure optimal and safe care for their babies.

Major Risk Factors for Sudden Unexplained Infant Death

- Infants sleeping on their stomachs
- Soft infant sleep surfaces and loose bedding, toys or other objects in sleep environment
- Maternal smoking during pregnancy
- Second-hand smoke exposure
- Overheating
- Prematurity and/or low birth weight
- Sharing a bed with others.
- Sleeping place other than crib (e.g., adult bed, couch, chair)
- Faulty design of cribs or beds.
- Obesity, fatigue, or drug or alcohol use by persons supervising or sleeping with child.
- Quality of supervision at time of death.
- Family's ability to provide safe sleep or play environment for child.

Prevention Efforts to Reduce Infant Deaths

- Education in childbirth classes and hospitals of expectant and new parents on safe infant sleep environments
- In-hospital assessments by nurses with parents to assess a baby's sleep environment when it goes home
- Crib distribution programs for families
- Parent education campaigns on room-sharing not bed-sharing
- Smoking cessation education and support for pregnant and parenting women and other caregivers
- Working with hospitals and providers to make sure that every infant that leaves the hospital has a primary care provider established
- Encouraging breastfeeding
- Pacifiers offered at each sleep
- Avoid products that claim to reduce the risk of SIDS
- Parents educated not to let baby get too hot
- The "Back to Sleep" campaign: baby sleeps on her back every time

⁴⁶ Public Act language can be found here:

https://www.cga.ct.gov/asp/cgabillstatus/cgabillstatus.asp?selBillType=Public+Act&which_year=2015&bill_num=39

- Specific messages targeted to families and childcare providers who traditionally practice stomach sleep positions and/or bed-sharing
- Education of health care providers on giving guidance on safe sleep and bed sharing to parents and caregivers
- Licensing requirements for daycare providers on safe sleep environments and infant sleep positions

Fact Sheet from the National Center for Fatality Review and www.ncfrp.org Prevention

Infant/Toddler Homicides in Connecticut

OCA/CFRP's Five Year Fatality Review noted that between 2011 and 2015 infants and toddlers (children under age 3) accounted for 27 out of the 78 homicides of children age birth to 17. Infant and toddler homicide victims generally die as a result of abusive head trauma and other forms of inflicted child abuse. OCA's reviews have found that the majority of perpetrators are men in the child's life—either the child's father or the mother's boyfriend.⁴⁷ Perpetrators often state that they were frustrated with the infant's behavior and did not have the skills to appropriately handle the situation.

Infant/Toddler Accidental Deaths in Connecticut

OCA/CFRP's Five Year Fatality Review found that between 2011 and 2015, 150 children age birth to 17 died from unintentional injuries that were classified by OCME as Accidental.⁴⁸ Thirty-seven (37) of these children were age birth to three.

Accidental Deaths of Children Age Birth to Three 2011-2015

- 1 child died in a fire.
- 2 children died from falls.
- 3 children died from choking.
- 9 children died in motor vehicle crashes.
- 9 children drowned (bathtubs and pools).
- **13 infants died from asphyxia/strangulation as a result of positional asphyxia or lay-over by an adult other children sleeping in the same bed.**

Toddler Fatalities from Benadryl/Antihistamines

⁴⁷ Over a 15 year period in Connecticut there were 69 homicides of children age birth to three. Over 75% of these young children sustained fatal child abuse associated with head and/or abdominal blunt force trauma. The significant majority of suspected and confirmed perpetrators for these deaths were male figures in the child's life—typically fathers or boyfriends of the child's mother.

⁴⁸ While the number of accidental deaths of children in Connecticut has appreciably declined compared to previous 5 year periods, accidental death remains the leading manner of preventable death of children in Connecticut and across the country. Generally, accidental/unintentional injuries are the result of motor vehicle crashes, drowning, fires, drug overdose, falls, positional asphyxia, and other injuries.

In May 2017, the OCA and the CFRP issued a Public Health Alert warning of the dangers of antihistamine administration to infants without prior direction from a pediatrician.⁴⁹ Specifically, the OCA/CFRP Alert cautioned that caregivers should never give antihistamines like Benadryl to infants to help them sleep or to keep them quiet, characterizing such practice as “dangerous.” The Alert notified the public that there had been four (4) recent deaths of infants and toddlers in the state due to toxicity from Benadryl or other antihistamines like chlorpheniramine (Chlortrimeton).

PREVENTION OF INFANT-TODDLER FATALITIES IN CHILD CARE SETTINGS- FINDINGS AND RECOMMENDATIONS

FINDING The Manner of Death for Nine Children in Child care Settings During 2016-17 is Consistent with Child Fatality Findings Statewide

The nine children who died in child care settings during 2016 and 2017 died in ways that are consistent with the general findings regarding child fatalities in Connecticut—death associated with unsafe sleep conditions, medication toxicity, blunt force trauma, and a range of natural but possibly preventable causes.

RECOMMENDATION

- It is essential that the state strengthen its public health campaign to prevent infant fatalities. Data continues to demonstrate that infants remain at significantly greater risk than older children for preventable fatalities attributable to death from unsafe sleep-related fatalities, ingestion injuries, accidental injuries, and homicide. The public health campaign contributors should examine critical and fatal injury trends associated with unsafe sleep practices, identify barriers to effective messaging and behavior change, and ensure work with necessary partners who may further assist with reaching families who present with greater risk-factors for experiencing a sudden infant death.⁵⁰
- The OEC’s licensing framework, inclusive of training, support, inspection, and corrective action should be informed by data regarding critical/fatal injury trends and prevention strategies for children age birth to three. Regulatory changes, provider education, inspection frequency, and the need for technical assistance, re-education and corrective action must be supported by data regarding risk and safety. For example, because death associated with unsafe sleep conditions is the leading cause of preventable death of infants in Connecticut, the licensing framework must ensure prioritization of

⁴⁹ Office of the Child Advocate/Connecticut Child Fatality Review Panel Public Health Alert: When is Benadryl Safe to Use With Children? (May, 2017). Found on the web at: http://www.ct.gov/oca/lib/oca/Benadryl_Public_Health_Alert.pdf

⁵⁰ Moon, R., Hauck, F., *SIDS Risk: It’s More Than Just The Sleep Environment*, Pediatrics Vol. 137/Issue I (Jan. 2016) (Discussing research regarding extrinsic risk factors for sudden infant death including pre and post-natal smoke exposure, and prenatal exposure to drugs and alcohol.)

education, monitoring and urgent corrective action regarding safe sleep practices in child care settings.

FINDING The Majority of Infant Deaths in Child Care Occurred in Unlicensed Settings—The Number of Infant Deaths in Child Care in 2016 and 2017 is a Marked Increase over Previous Periods of Review.

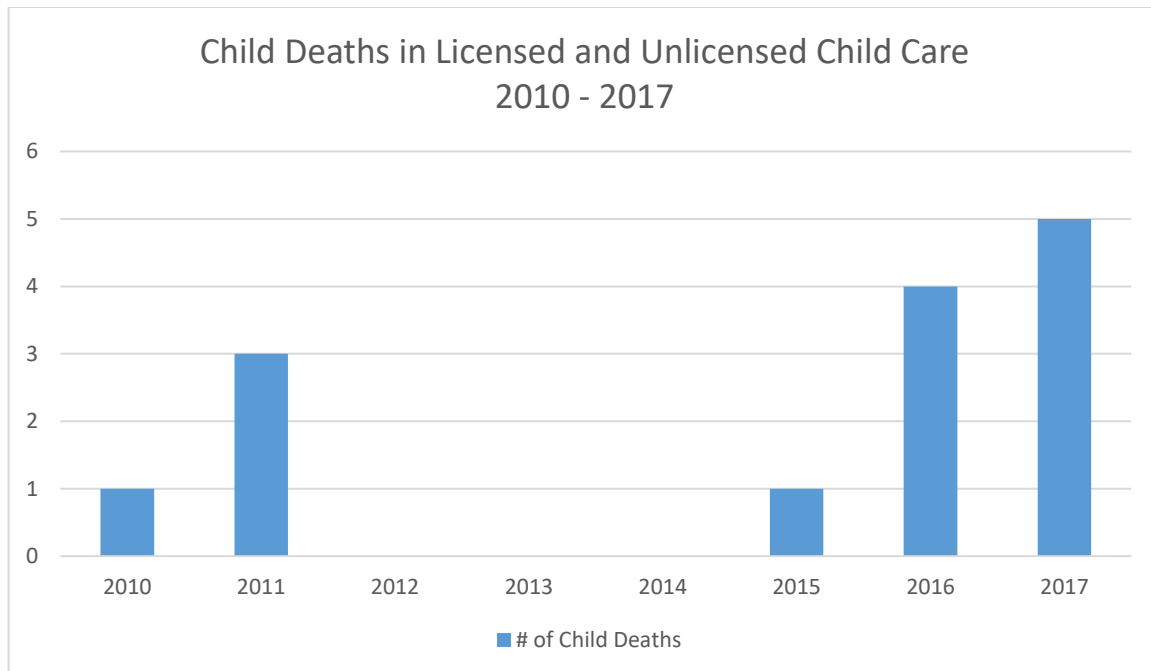
Between March 2016 and November 2017, there were nine recorded infant and toddler fatalities that occurred in separate non-relative home child care settings, licensed and unlicensed (all but one determined by the OEC to be operated illegally). But notably, six of the nine children who died in child care were being cared for in unlicensed settings.

Trends were determined by OCA after reviewing child fatality information for the past 10 years collected by OCA, as well as child fatality information collected by the Office of Early Childhood corresponding to the same time period. OCA’s review indicates that the nine deaths of children in child care settings during 2016-17 is a marked increase in child care-based child fatalities. By comparison, the previous twenty-four month period (February 2014 through February 2016) included documentation of only one infant death in a licensed home-based child care. The previous five years of OEC’s data indicates that from 2010 through 2015 there were a total of five infant/toddler deaths in child care. See chart below.

There were *no* reported deaths of Connecticut children in licensed center-based child care settings in 2016 and 2017.

According to the U.S. Department of Health & Human Services, research shows young children are more likely to be injured or die in [home-based child care] than in centers.

Source: Admin. For Child. & Families, *Enforcement and Approaches with Illegally-Operating Providers* (Aug. 2014)



Children under age three are most at risk for critical and fatal injury. Children under the age of twelve months are most at risk for preventable death from conditions associated with unsafe sleep

environment. Child care providers must be well-versed in infant care, hazards and risks presented by “unsafe sleep” environment for babies under twelve months of age, fall prevention, administration of medication to young children, and responding/supporting children’s developmental and special health care needs.

With regard to the deaths of babies in unlicensed child care, OCA notes that low-income families’ access to child care subsidies through the state’s Care 4 Kids program was sharply diminished between July 2016 and December 2017. At that time access to Care 4 Kids for new babies was eliminated for most families (unless otherwise enrolled in the program with a sibling). The reason for the shut-off was lack of funding.⁵¹ Funding for this program has since been increased at both the state and federal level.

RECOMMENDATIONS

- The OEC, in collaboration with state agencies such as OCA and DCF, should continue to examine data regarding utilizers of illegal child care where critical or fatal injuries have occurred, and help determine the common factors that may drive use and operation of unlicensed care in Connecticut. Experts note that “many parents and illegal child care providers do not understand the licensing law,” and that a “community education campaign” should be used to educate parents *and* child care providers “about the benefits of regulated child care.”⁵²
- OCA strongly recommends that lawmakers maintain and continue to strengthen low-income families’ access to high-quality licensed infant-toddler child care as a matter of public policy (a) to improve health and safety outcomes for young children, and (b) *as a strategy to support child fatality prevention*.
- The OEC and its partners should continue work with community-based providers and support networks, including local faith-based organizations and groups that work with immigrant families, to disseminate information to families about access to child care for low-income families, the importance of utilizing licensed child care, the availability of child care to families regardless of their country of origin.

According to Child Trends, a nationally-focused non-profit that studies and issues reports regarding public health issues affecting children, “[a]n estimated 5.1 million children in the United States live with at least one unauthorized immigrant parent, and nearly 80 percent of

⁵¹ Specifically, in July and August 2016, the Care 4 Kids program was closed to a population of Connecticut families that represented 66% of new would-be participants. In December 2016, Care 4 Kids was closed to an additional 25% of new would-be participants, meaning that the program was now closed to 91% of new would-be participants and 87% of would-be new infant participants. The Care 4 Kids program remained opened for priority 1 group families; historically priority 1 group families made up about 9% of the Care 4 Kids population, with infants accounting for about 13% of the priority group 1 population.

⁵² U.S. Dep’t. of Health and Human Services, Administration for Children & Families Office of Child Care, *Contemporary Issues in Licensing: Enforcement and Approaches with Illegally-Operating Providers*, at 5 (**ACF Enforcement Memo**). Found on the web at: https://childcareta.acf.hhs.gov/sites/default/files/public/1408_illegally_operating_providers_final.pdf.

those children are U.S. citizens.”⁵³ While applicants for federally-funded benefits are subject to citizenship and immigration status verification, regulations provide that for the purpose of child care assistance, only the *child’s* citizenship or immigration status is relevant to eligibility.⁵⁴ Messaging to immigrant communities should include clear information about access and availability to child care supports.

- The OEC should be supported in its current work to markedly increase availability of and access to high quality child care for infants and toddlers. The OEC is contemplating and taking steps to gradually increase access to care and measure the impact on the provider system and children. In recent years, the state’s investment in infant-toddler care has significantly lagged behind its investment in pre-school education. The OEC, in frequent meetings and conversations with the OCA, has articulated its vision for a robust investment in infant-toddler care opportunities across Connecticut, recognizing that high quality infant-toddler care supports an optimal child development trajectory.
- The OEC’s marketing campaign for licensed Child care should inform consumers as to key questions they should ask of any child care provider—e.g., license and inspection information, staffing ratios, medication administration policies, and safe sleep practices.

FINDING OEC Licensing Standards, Training and Inspection/Corrective Action Protocols Need to be Strengthened with Regard to Safe Sleep Requirements-OEC has Been Working to Improve Safe Sleep Fatality Prevention Efforts

Regulations

Historically, Connecticut’s home-based child care licensing standards, originally promulgated by the Department of Public Health, have contained no specific reference to safe sleep guidelines and risk factors. The OEC, which has been in charge of licensing child care since its legislative establishment in 2014, is currently finalizing new regulations and directives for child care programs, including home-based child care. For the past several years the OEC has been a partner in the state’s public health communications campaign regarding safe-sleep fatality prevention, along with the Department of Children and Families, the Department of Public Health and the Office of the Child Advocate. The OEC’s website includes important information about safe-sleep guidelines for the public and providers, and the OEC has been distributing safe sleep information to all of its licensed providers. Ensuring a comprehensive regulatory approach to training, licensing inspection and enforcement will be a critical measure to support the current public health campaign.

Two of the three infants who died in licensed child care programs between 2016 and 2017 were found by the Office of the Chief Medical Examiner to have died from Sudden Unexplained Infant Death, and neither infant was sleeping in a manner consistent with AAP recommendations: one child was swaddled and placed on her stomach to sleep, and the second child was placed on his side to sleep with a blanket wrapped around him. These infants were three and four months old, the median age in

⁵³ See Child Trends fact sheet on children of undocumented parents. Found on the web at: <https://www.childtrends.org/new-deportation-policies-place-kids-risk/>

⁵⁴ Matthews, Hannah *Immigrant Eligibility for Federal Child care and Early Education Programs*, Center for Law and Social Policy (Apr. 2017). Found on the web at: <https://www.clasp.org/sites/default/files/public/resources-and-publications/publication-1/Immigrant-Eligibility-for-ECE-Programs.pdf>.

Connecticut for unsafe sleep-related fatality.⁵⁵ Another child, who died at three months of age in an unlicensed child care, and whose manner of death was determined to be from Natural causes by the Office of the Chief Medical Examiner, was also noted to be in an unsafe sleep position--lying on his stomach on the provider's bed.

While state law was amended in 2015 to require all hospitals to disseminate information regarding safe sleep practices to new parents, OCA notes there is no similar statutory provision or regulation that requires child care providers to receive training or information regarding safe sleep practices, or to disseminate such practices to parents whose children are enrolled in their child care programs. Yet the AAP recommends that "health care professionals, staff in newborn nurseries and NICUs, and child care providers should endorse and model the SIDS risk-reduction recommendations from birth, and that "[a]ll state regulatory agencies should require that child care providers receive education on safe infant sleep and implement safe sleep practices. It is preferable that they have written policies."⁵⁶

Proposed draft regulations developed by the OEC amend the existing yet deficient "proper rest" regulations applicable to home-based child care in a variety of important ways:

- Requires providers to adhere to safe sleep standards for infants including back positioning for sleep "unless the child has written documentation from a physician, physician assistant or advanced practice registered nurse specifying a medical reason for an alternative sleep position or alternate piece of equipment."
- Includes requirement that there be an "individual bed, cot, mat or other provision intended for each child for napping or resting which is age appropriate" and "children shall nap or rest on such bed, cot, mat or other provision."⁵⁷
- Provides that "all cribs must comply with the U.S. Consumer Product Safety Commission crib standards."⁵⁸
- Clarifies that "when infants can easily turn over from the supine to the prone position, they shall be put down to sleep on their back, but allowed to adopt whatever position they prefer for sleep."⁵⁹
- Prohibits the placement of any items, including pillows, bumpers, toys or blankets in the crib absent written documentation from a health care provider. A pacifier without attachments may be placed in the crib with the infant.⁶⁰

⁵⁵ OCA/CFRP Alert: Unsafe Sleep Related Deaths are the Leading Cause of Preventable Deaths of Infants in Connecticut (Apr. 2014). Found on the web at:

http://www.ct.gov/oca/lib/oca/PublicHealthAlert_Safe_SleepApr_7_FINAL__docx_%282%29.pdf

⁵⁶ Pediatrics SIDS and Other Sleep-Related Infant Deaths: Updated 2016 Recommendations for a Safe Infant Sleeping Environment TASK FORCE ON SUDDEN INFANT DEATH SYNDROME (October 2016)

From the American Academy of Pediatrics Policy Statement. Found on the web at:

<http://pediatrics.aappublications.org/content/early/2016/10/20/peds.2016-2938>

⁵⁷ Draft Regulation § 19a-87b-10. *See* n. 6.

⁵⁸ *Id.*

⁵⁹ *Id.*

⁶⁰ *Id.*

- Specifies that no infant may be put to sleep “on a sofa, bed, couch, soft mattress, waterbed or other soft surface ... infant carrier, [or] swing...” without written documentation from a health care provider specifying a medical reason.
- Requires that providers post the safe sleep requirements in a “conspicuous place” and “discuss with the child’s parent(s) the requirements of the [regulations] pertaining to sleep arrangements prior to enrollment and reviewed as needed during the period of the child’s enrollment.”⁶¹
- Provides that an infant may not be swaddled for sleep absent written documentation from a health care provider, though a medical reason is not required.

The OEC’s proposed draft regulations regarding safe sleep practices are consistent with the latest recommendations and research from the American Academy of Pediatrics and should be swiftly finalized and implemented for all child care providers.

Training

Training requirements for home-based child care providers historically have not contained explicit reference to safe sleep practices or standards. The current regulations require that the provider demonstrate he or she has been trained in “basic first aid appropriate for child care providers.” Proposed new regulations strengthen this requirement to specify that the certification of completion must come from the American Red Cross, the American Heart Association, the National Safety Council, or other similarly situated organizations, and that such verification shall include certification in CPR.⁶² Draft regulations would also require the provider to “maintain verification of current certification in first aid and [CPR]” and maintain verification of such training in the home-based Child care.⁶³

There is no current training requirement in state regulations applicable to home-based child care programs or in the proposed draft regulations that require training regarding adherence to safe sleep practices or problem-solving regarding sleep challenges with infants. While information and technical assistance regarding safe sleep practices is available on the OEC website, clear training curricula and regulations regarding ongoing training related to safe sleep requirements are a critical prevention measure to reduce sleep-related fatalities. Notwithstanding the lack of state regulatory or statutory mandate regarding safe-sleep training, new federal requirements regarding publicly-funded child care subsidies do require that providers be trained on infant health and safety, which training includes information about infant safe-sleep. These requirements are in the process of being implemented in Connecticut for providers who receive Care 4 Kids subsidies.

AAP recommendations emphasize the need for ongoing public and provider education, “focusing on ways to reduce the risk of all sleep-related infant deaths,” and that “[p]ublic education should continue for all who care for infants, including parents, child care providers, grandparents, foster parents, and babysitters, and should include strategies for overcoming barriers to behavior change.”

Inspection Manual

⁶¹ *Id.*

⁶² Draft Regulation § 19a-87b-6. *See also* n. 6.

⁶³ *Id.*

The current OEC inspection manual is silent regarding certain safe sleep issues, including how specifically to monitor providers' adherence to AAP Safe Sleep Guidelines, how to categorize provider violations of safe sleep recommendations in terms of risk and severity, what inspection and re-inspection timeframes (as well as corrective actions or re-training) should apply to support infant safety and ensure providers' fidelity to safe sleep practices.

OEC does have a newly drafted "Policy for Additional Monitoring Visits of Licensed child care Programs," which policy provides for additional partial inspection to be conducted in situations in which concerns are identified with regard to certain violations, such as 1) safe sleep; 2) ratios; 3) group size; 4) capacity; 5) supervision; 6) unapproved staff; or 7) repeated and/or substantial noncompliance. However, the new policy, which provides that such partial re-inspection is intended to be "in addition to any follow-up visits conducted as part of the original inspection," does not specify a timeline for such re-inspection other than it shall be "conducted 2-3 months" after the date of the last follow-up.⁶⁴ The OCA urges consideration of a more prescriptive timeframe for follow-up with regard to certain regulatory violations and a clear inspection strategy for enforcement and provider support.

Supervision and Safe Sleep

Current regulations state that a home-based provider may not care for more than two children under the age of 2 years old at one time, including his or her own children. Given that children under the age of 12 months are the most vulnerable to critical and fatal injury, accidental or intentional, Connecticut regulations appropriately limit the number of infants and toddlers that can be placed in a home-based child care.⁶⁵

Regulations also appropriately mandate that providers are responsible for supervision of the children "at all times," and that providers must be "within effective sight or sound of the children." There are no current regulations specifying where children can sleep relative to the provider, such as whether infants must sleep on the same floor as the provider, or when monitors may or must be used to ensure effective supervision of a napping infant.

Proposed draft regulations clarify that while the home-based child care provider may serve more than two children under 2 years of age in the child care if there is an approved staff present, the approved staff is required to be present "and assisting the provider" with such care.⁶⁶ Draft regulations further provide that "[m]onitoring devices shall not replace supervision by the provider," suggesting that while monitors may be used to assist with supervision during sleep, that a sleeping child must still be within sight or sound of the provider and close enough to be heard even without the assistance of a baby monitor. *This regulation could be further clarified with regard to supervision of sleeping babies.*

RECOMMENDATIONS

⁶⁴ OEC shared written information, dated January 29, 2018, with the OCA which says that with regard to the new additional monitoring policy, typically a follow-up inspection will not be conducted until after a corrective action plan is received (i.e. within 14 days), but that "when there is a significant violation that raises serious concern and it is decided that we don't want to wait for the CAP to be mailed in," the follow-up visit can take place sooner.

⁶⁵ Regulations do permit up to six children under the age of two if there is an approved staff present.

⁶⁶ Draft Regulation §19a-87b-8; *See* n. 6.

- The OEC should swiftly adopt new regulations which strengthen and clearly articulate appropriate standards for infant safe sleep practices. Continued attention should be paid to ensuring regulations address supervision and monitoring of sleep infants.
- The OEC should establish pre and post-licensing training requirements for all child care providers regarding safe sleep requirements and, consistent with AAP recommendations, strategies for overcoming barriers to safe sleep.
- The OEC inspection manual should be examined to ensure prioritization of safe sleep reviews with providers, consideration of a risk classification/severity score for safe- sleep violations, a specific timeframe for announced and unannounced re-inspection after concerns regarding safe sleep develop, and a framework for corrective action, technical assistance and re-training for providers to support adherence to safe sleep requirements.
- Similar to state law passed in 2015 that requires all hospitals to disseminate information regarding safe sleep practices to new parents, lawmakers should consider a similar statutory provision that requires child care providers to receive training regarding safe sleep practices and to disseminate and discuss safe-sleep information with parents whose children are enrolled in their child care programs.

FINDING The OEC Did Not Ensure Ceased Operation by Baby K’s Child Care Provider, Which Provider Continued to Operate until Baby K’s Death.

The OEC’s child care Licensing Policy and Procedure Manual spells out the steps that staff must take to verify that a child care provider whose license to operate has been revoked has ceased providing child care. The policy provides that staff “shall conduct a follow-up on-site visit to all providers/operators whose license was summarily suspended, voluntarily surrendered, revoked or lapsed following the change in license status to verify that care has ceased. If an adult is present at the time of the visit and it can be verified that care has remained ceased, no further visits are necessary. If no adult is present, staff shall make at least two more attempted visits to verify operation has remained ceased... All attempted follow-up visits shall be documented on a supplemental inspection form, and entered into the licensing data system and spreadsheet on the shared drive.”⁶⁷

Baby K., died from viral myocarditis and influenza A. infection while in the care of an illegal child care provider whose license to operate had been revoked the year before for multiple regulatory violations, including failure to adhere to licensed capacity and failure to adequately supervise the children in her care. At the time of Baby K’s death, there were eight children in the home, including the provider’s three children. The ages of the children ranged from 8 months old to 10 years old. There was no baby monitor found where Baby K. was sleeping. OEC records document only one visit to the home after the provider’s license was revoked in 2015, wherein the provider did not appear to be home. OEC records do not reflect that additional visits/contacts with former provider were attempted. OEC records also do not indicate that parents were contacted at the time the provider’s license was revoked. Multiple parents told investigators after Baby K’s death that they did not know the provider’s license had been revoked.

⁶⁷ OEC Child care Licensing Policy and Procedures Manual, pg. 37.

RECOMMENDATION

- OEC must ensure that licensing staff adhere to agency policies and practices regarding verification of ceased child care operations, up to and including requiring Commissioner approval before a case involving licensing revocation may be closed. Where ceased care cannot be verified despite multiple visits to the home, Commissioner review of the matter should be required.
- OEC must ensure that parents are informed whenever there is a significant regulatory action taken against a licensed or unlicensed child care provider, and re-inspection or corrective action forms should reflect this requirement.⁶⁸ OEC has communicated to OCA that a new policy has been developed to ensure parental notification.

FINDING OEC Continues to Strengthen its Approach to Data Collection and Incident Reporting—Further Development Needed

OEC's proposed draft regulations add to the child care provider's incident reporting requirements by mandating that the OEC be notified whenever a child at the program suffers an injury which results in "a diagnosed fracture, diagnosed second or third degree burn, diagnosed concussion," or the child being admitted to a hospital or the child's death."⁶⁹

The OEC is beginning on its own and in collaboration with other state partners, including the OCA, to collect data regarding significant and critical injuries to children in the state and to utilize such data to inform its licensing and oversight framework for child care programs.

In multiple conversations with the OCA, the OEC leadership has committed to and shared its vision for a robust and data-driven approach to ensuring provision of high quality child care opportunities across the state. The OEC has submitted legislation, recently enacted into a Public Act, intended to enhance its capacity for agency evaluation and improvement through strategic use of allotted program funds.⁷⁰

Gaining reliable and regular data regarding injuries to children, broken down by age and setting, will be critical to ensuring a child care oversight system that is strategically designed to prevent infant/toddler injury and promote children's health and well-being.

RECOMMENDATION

- It will be important that the OEC have access to reliable data regarding injury occurrence in licensed and, where applicable, unlicensed child care programs, with such data broken down

⁶⁸ OEC recently implemented a process to ensure that parents are informed when known operation ceases at a legal or illegal facility.

⁶⁹ Draft Regulation § 19a-87b-10; *See* n. 6.

⁷⁰ House Bill 5449. Full text of bill can be found:

https://www.cga.ct.gov/asp/cgabillstatus/cgabillstatus.asp?selBillType=Bill&which_year=2018&bill_num=5449

by injury type and age of child (by year) to best inform the agency's prevention and corrective actions. OEC may consider partnering with various hospitals' and hospital association's injury prevention centers to inform development and dissemination of prevention strategies.

- OEC must be supported in its efforts to ensure a data-driven and accountable framework for the provision of high quality infant-toddler care and early childhood education to children across the state, which will require investment in additional infrastructure for OEC.

FINDING The OEC Does Not Have a Method of Correlating the Severity of the Regulatory Violation(s) with Instances of Harm to Children Enrolled in Licensed Facilities so as to Better Inform Decision-Making With Regard to the Continuum of Corrective Actions and Child Protective Activities.

The OEC found regulatory violations during multiple inspections of several of the home-based child care programs discussed in this report. The OEC does not use a system to rate the severity of regulatory/licensing violations through a classification system. The OEC should consider whether the development of such a classification system would aid in strategic use of resources and corrective actions by agency inspectors. In reviewing the licensing histories of child care providers discussed in this report, OCA was unable to conclusively characterize the nature or severity of the identified licensing violations based on the available information in the record and the lack of an objective framework for determining violation severity or the risk the violation poses to the health and safety of children.

The OEC's regulations and agency manuals do not currently include a formal framework for ranking, rating or classifying child care regulatory violations. The OEC's Licensing Policy and Procedures Manual does not include an objective method of determining what level of disciplinary step to take when a home-based child care is in violation of state regulations based on the particular type of violation, the number of violations, the repeat instances of violations and/or how long it takes to correct the violations when a corrective action plan is ordered by the OEC.

Experts recommend that licensing agencies:

[m]aintain a research-based risk-assessment method whereby industry-wide and facility-specific risks, including both immediate and cumulative risks, are identified and prioritized; focuses inspections and technical assistance accordingly; and, applies the agency's enforcement continuum systematically to avert or abate priority risks, to build consistent compliance, and to improve overall consumer protection across all relevant domains.⁷¹

RECOMMENDATION

⁷¹ U.S. Dep't. of Health and Human Services, Administration for Children & Families Office of Child care, *Contemporary Issues in Licensing: Monitoring Strategies for Determining Compliance: Differential Monitoring, Risk Assessment, and Key Indicators (ACF Monitoring Memo)*, found on the web at: https://childcareta.acf.hhs.gov/sites/default/files/public/1408_differential_monitoring_final.pdf, quoting *Recommended Best Practices for Human Care Regulatory Agencies* (2009) published by the National Association for Regulatory Administration (NARA).

- Consistent with recommendations above for a data-driven approach to injury prevention and corrective action, a classification system should be considered that is responsive to reliable information regarding the most prevalent risks of harm to children, disaggregated by age. For example, so long as infant deaths corresponding to unsafe sleep environment remain the leading cause of child fatality in the state, then violations of regulatory standards and agency directives regarding provider safe sleep practices/training requirements must be classified as a concerning violation, with a clear protocol for agency follow-up, urgent re-inspection, re-training and corrective action.

Should data review indicate that accidental injury, from falls or medication administration errors, is one of the most common type of injuries leading to emergency room visits and hospitalizations for children age birth to twelve months, then regulatory or agency violations related to supervision and fall prevention would be classified as more severe than other types of hazards or concerns, leading to, again, a more urgent and prescriptive protocol for follow-up by OEC regulators.

Some other states utilize progressive enforcement based on prescribed procedures and classification of violations.⁷² For example, in Texas, licensing staff are required to conduct a follow-up inspection within 15 days of a compliance date for serious violations that may include staffing ratios, supervision, child discipline, or physical facility hazards.⁷³ According to federal authorities, Florida “credits the effectiveness of its progressive enforcement program to changes in prescribed procedures established by rule and outlining progressive disciplinary sanctions. [Florida] saw a continual decline in class 2 and 3 violations from 2010 to 2013... If a provider fails to comply with minimum health and safety standards during a two-year period, more serious progressive sanctions will be taken, ... [and] a program’s Gold Seal Quality Care Designation may be impacted by compliance history.”⁷⁴ Texas also has an automated risk review system that will raise “red flags,” scan inspection findings and recommend prescribed levels of monitoring or enforcement. These recommendations can be over-ridden by agency regulators.⁷⁵

⁷² ACF Monitoring Memo, *supra* n. 71, at 8; *See also* **ACF Enforcement Memo**, *supra* n. 52.

⁷³ Administration for Children & Families, Office of Child Care, *Contemporary Issues in Licensing: Enforcement Strategies with Licensed Child care Providers*, at 5 (**ACF Enforcement Strategies Memo**). Found on the web at: https://childcareta.acf.hhs.gov/sites/default/files/public/1408_enforcement_licensed_final.pdf.

⁷⁴ *Id.*

⁷⁵ *Id.* at 6.

Strategies States Use to Identify and Reduce the Risk of Harm to Children

- ✓ Identifying licensing rules where violations pose a greater risk to children;
- ✓ Assigning a weight to each rule to further distinguish levels of regulatory compliance;
- ✓ Focusing monitoring visits on key indicators from the rules that predict compliance and reduce risks;
- ✓ Increasing monitoring frequency for programs with low levels of compliance;
- ✓ Increasing monitoring depth for programs with low levels of compliance;
- ✓ Helping providers, parents, and licensing staff better understand the potential consequences of serious noncompliance;
- ✓ Identifying providers in need of technical assistance; and
- ✓ Using more sophisticated data systems to target case management and improve consistency in enforcement actions.

ACF Monitoring Memo, *supra* n. 71, at 1.

RECOMMENDATION

- Connecticut should consider development of a regulatory or inspection framework that utilizes a classification or rating system, informed by data regarding critical risk and well-being indicators for young children.
- Classification and a data-driven approach to regulatory violations should drive a more specific framework for provider re-education, technical assistance, and corrective action.
- The state should support OEC's capacity to utilize data and performance indicators to help it determine the best continuum of prevention and enforcement remedies that will promote compliance with agency requirements and best practices among providers.

FINDING Connecticut Does Not Yet Use a Quality Rating System for Child Care Programs—OEC's QRIS Development Is In Progress

Multiple states are now utilizing a quality rating system (QRIS) for state-licensed/funded child care programs.⁷⁶ QRIS systems seeks to promote and encourage high quality and safe child care and reductions in QRIS ratings can be undertaken when the regulatory agency has concerns about child safety or well-being in the program.⁷⁷ Connecticut is currently developing a QRIS model.

RECOMMENDATION

- OEC should be supported in its effort to develop and evaluate the efficacy of a QRIS system for child care programs for enhancing child well-being and safety outcomes.

⁷⁶ FLA, GA, OK, e.g., ACF Enforcement Strategies Memo, *supra* n. 73, at 16.

⁷⁷ *Id.*

CONCLUSION

The OCA worked closely with the OEC in the review of the tragic child deaths discussed in this report. Both agencies agree that prioritization of access to high quality and subsidized infant-toddler care for families across Connecticut is a critical public policy priority for the state. Throughout the development of this report, the OEC has been working to strengthen its licensing framework, improve its access to data regarding child injury prevalence rates, and create opportunities to strengthen the state's infrastructure for supporting infants and toddlers. The OCA supports the OEC's work in all of these endeavors and shares its commitment to eliminate all preventable infant-toddler deaths in the state of Connecticut.

This review is respectfully offered in memory of the children whose deaths are discussed in this report, and in support of the families who love and mourn them.