



CONTEMPORARY ISSUES IN LICENSING: Reporting, Tracking, and Responding to Serious Injuries and Fatalities in Child Care

Introduction

States promulgate and monitor compliance with licensing rules to protect children’s health and safety, but – almost weekly, according to national news reports—these safeguards fail to protect children in care.

Unfortunately, only about half of States require licensed child care programs to report serious incidents (including serious injury and death) to the child care licensing agency, and there is variability across the country in both the definition of serious injury and the information that States require child care providers to report.

This report, one in a series of reports on contemporary issues in licensing, focuses on practices and policies pertaining to reporting, tracking, and responding to serious incidents in child care. Data from national and state sources, while limited, provide an opportunity to explore recommendations based on lessons learned and best practices of the States surveyed, for ways that States can better monitor and respond to serious injuries and fatalities in child care.

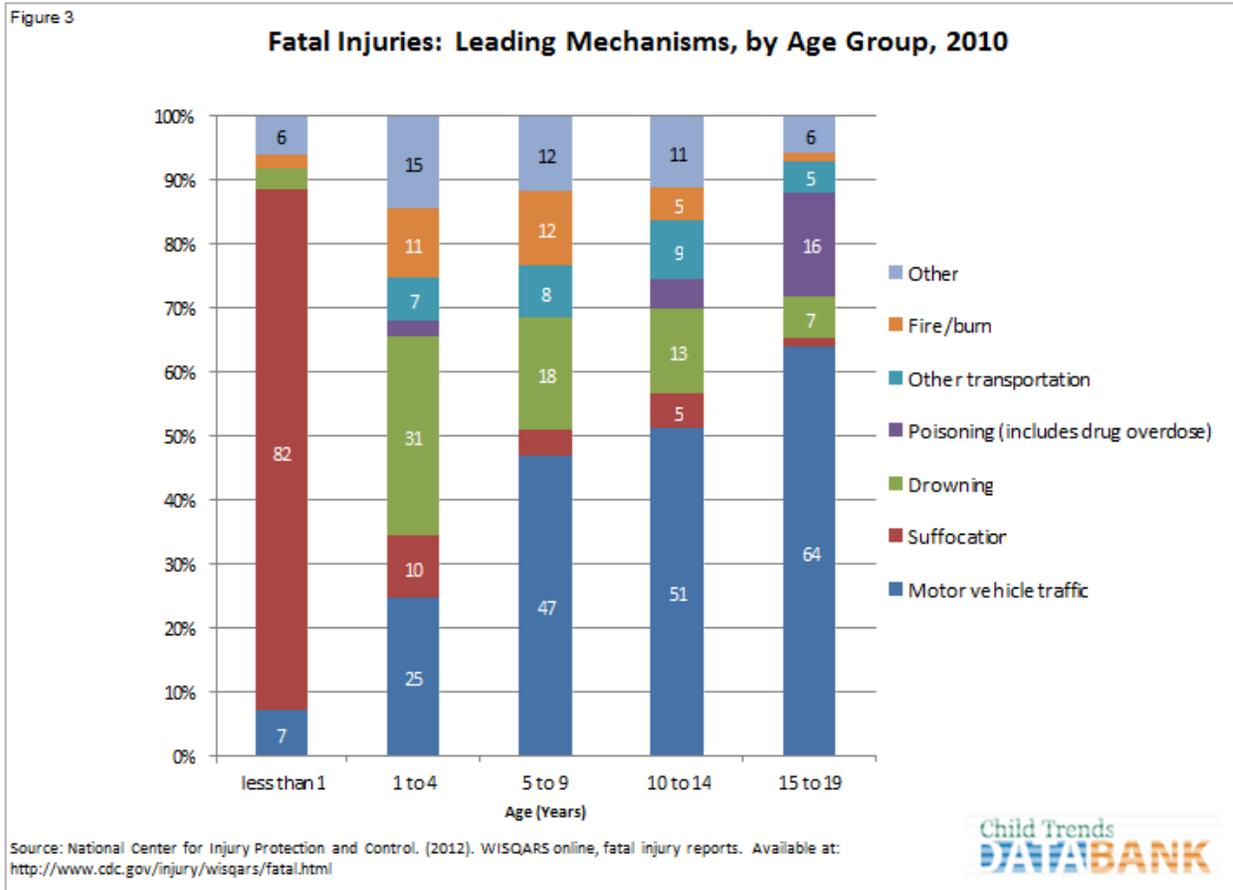
Background

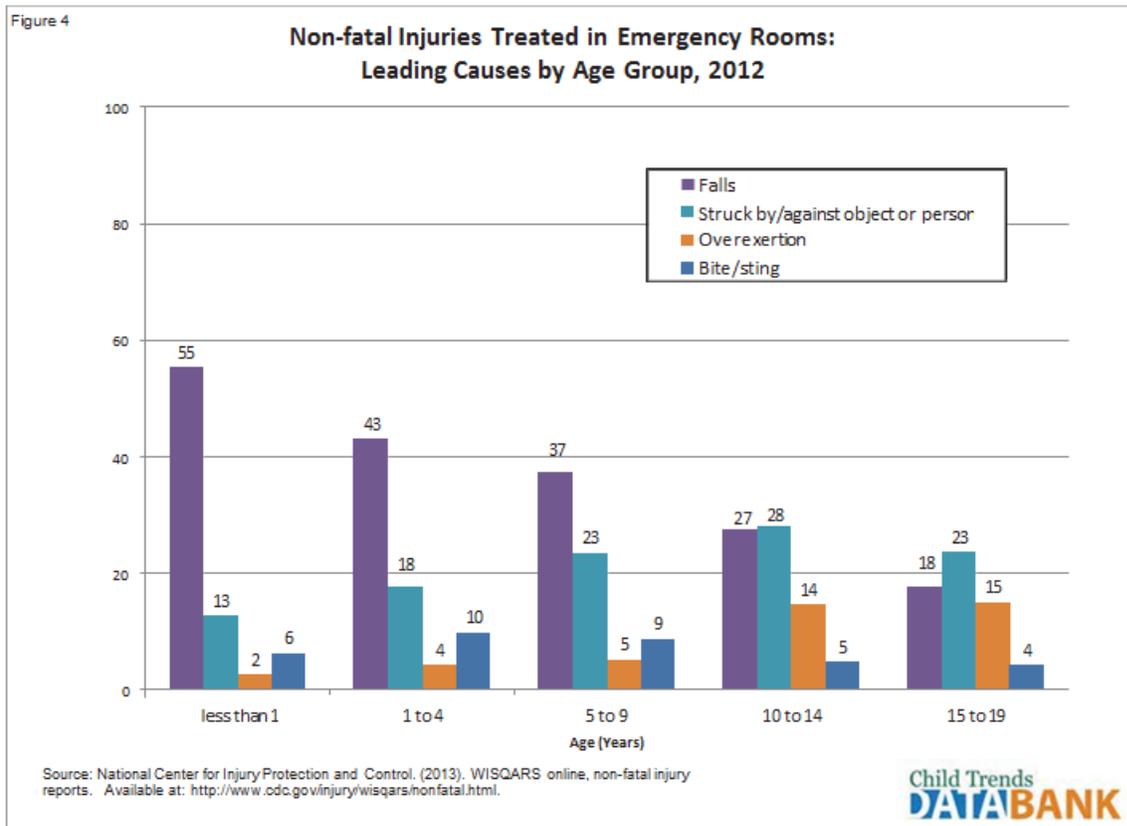
The Centers for Disease Control and Prevention (CDC) provides the only comprehensive ongoing source of data on child injuries and deaths;¹ and while the data don’t specify whether the injuries or deaths occurred in child care, they provide startling insights into the scale of child fatalities and injuries in the United States. Child injuries (unintentional injuries that occur among children and teens ages birth – 19 years) are preventable, yet more than 9,000 children died from injuries in the U.S. in 2009. Injuries are the number one cause of death among children in this country. According to the CDC (2012a), the U.S. child injury death rate is among the worst of all high-income countries. Car crashes, suffocation, drowning, poisoning, fires, and falls are some of the most common ways children are hurt or killed (CDC, 2012a). Each year, 8.4 million children and teens are seen in emergency departments for injuries, and injury treatment is the leading cause of medical spending for children. The estimated annual cost of unintentional child injuries in the United States is nearly \$11.5 billion (CDC, 2012b).

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¹ Data are derived from the Web-based Injury Statistics Query and Reporting System and the National Health Interview Survey.

Unintentional fatal injuries are most common among infants. The 2010 rates per 100,000 population range from a high of 28.1 among children younger than one year, to a low of 3.7 among those ages five to nine. The following charts from the Child Trends Data Bank report, *Unintended Injuries* (November, 2012), illustrates that the most common causes of both fatal and non-fatal injuries differ among age groups. Further breakdowns of the 10 leading causes of death and injury by age group are available from the CDC at <http://www.cdc.gov/injury/wisqars/LeadingCauses.html>.





While the National Child Abuse and Neglect Data System (NCANDS) includes some information about abuse and neglect of children in child care, child fatality information depends on varied state reporting requirements. The *Child Maltreatment Report 2012* conveys that 14 of the fatalities reported in 2012 were perpetrated by the child’s “Daycare Provider,” but that additional child care deaths may be included under the category “Friends and Neighbors” (HHS, 2013). Other organizations that collect data on child deaths, such as the National Center for the Review and Prevention of Child Deaths and the National Violent Death Reporting System, may depend on voluntary reporting or on data from state-level child death review programs, which differ widely. As a result, they do not include data from all States nor specify whether fatalities occurred in a child care setting.

Minnesota Sees Decline in Child Care Deaths

In December 2012, the Star Tribune, in Minneapolis, Minnesota, reported on a “sharp rise in child care deaths in Minnesota since 2007” based on a report issued by Minnesota’s Department of Human Services’ Child Mortality Review Panel. The analysis, entitled *Review of Child Deaths in Minnesota Licensed Family Child Care Homes January 2002-August 2012*, involving 83 children over the decade, revealed that:

There has been an increase in the number of deaths in licensed family child care homes since 2006. Ninety-six percent of deaths in licensed child care facilities between 2002 and the first seven months of 2012 occurred in licensed family child care homes. Seventy-five percent of the deaths occurred when the infant was sleeping or in a sleep environment. Forty-two percent of the providers were issued licensing sanctions related to violations of safe infant sleep requirements. In eighteen percent of the infant deaths that occurred while sleeping, details about the sleep environment are unknown. Ten percent of the providers were issued licensing sanctions because they were found to be over capacity at the time a child died. In twenty-three percent of the deaths in child care, the number of children present in the home is unknown because it was not documented in law enforcement reports. Five percent of the children died from choking, five percent died from abusive head trauma, and nine percent died from a serious illness (Minnesota Department of Human Services, August 2012; Schrade and Olson, 2012).

In addition to an examination of the children’s deaths, the report put forth recommendations including rule changes, public awareness, oversight, training, and further research.

The Star Tribune continued to investigate and in April 2013, reported on a sharp decline in deaths over the previous eight months, attributed, at least in part, to “stepped up enforcement, with more fines for providers who ignored safe sleep practices, and increased communication to the 11,000 in-home providers across the state” (Schrade, 2013). Minnesota’s experience highlights the value of quality data on child deaths; a thorough mortality review allowed the State to pinpoint where specific remedies could be enacted to prevent future deaths. High quality, consistent, and ongoing data collection allows States to continually examine and refine policies and practices.

The last comprehensive report about fatalities in child care was published in 2005, and includes data from 1985 – 2003. *Fatalities and the Organization of Child Care in the United States* (Wrigley & Dreby, 2005) relies on data from three sources: (1) a systematic national media search for 1985 – 2003, (2) legal records of civil and criminal court cases involving fatalities and serious injuries in child care, and (3) ethnographic data from state records in seven States. The authors found evidence of 1,362 fatalities in child care programs, 1,030 of which occurred in home-based care (family child care [FCC] or in-home care). These numbers exclude children who died in irregular care arrangements with the same provider and children whose deaths were attributed to natural causes, including Sudden Infant Death Syndrome (SIDS). The authors conclude that although overall child care was safe, fatality rates in home-based care were considerably higher than in child care centers.

Methodology

To support OCC’s goal of children served in safe, healthy child care settings, the National Center on Child Care Quality Improvement (NCCCQI) contracted with a group of nationally-recognized consultants with expertise in administering and researching licensing systems to prepare a series of written reports about critical licensing issues.

The information provided in these reports was obtained by surveying and interviewing representatives of state licensing agencies in nine States: **CT, FL, GA, NC, OH, OK, TX, UT,** and **WA**. The States selected are not a representative sample but were chosen based on the consultants’ knowledge that they are implementing effective and innovative practices which may be helpful to other state licensing agencies. Additionally, an effort was made to achieve some degree of geographic representation through the States selected.

Licensing personnel from the nine States selected first completed a written survey instrument and then spoke with the consultants in a telephone interview. All individuals interviewed were licensing agency directors or top-level administrators.²

Reporting and Tracking State Data

Reporting Serious Injuries and Fatalities

The absence of a consistent definition of “serious injury” limits the ability to aggregate data across States. Many States require reporting when medical attention is required. However, **Florida** defines serious injury as “resulting in death or serious harm to a child;” **Connecticut** requires reporting only if the injury results in admission to a hospital; and **Georgia** does not include a definition of serious injury in its regulations. The serious injury reporting requirements in **Florida, North Carolina, Texas,** and **Georgia** specify that medication errors must also be reported. In **Washington**, medication errors are considered serious injuries only if medical treatment is required.

The following table from the NCCCQI trends analysis (2013a, 2013b, 2013c) shows the number of States that require child care providers to report serious injuries or deaths to the licensing agency.

Reporting to the Licensing Agency	Child Care Centers (N = 50)	FCC Homes (N = 42)	Group Child Care Homes (N = 38)
All serious injuries that occur to children in programs	34	31	25
All deaths that occur to children in programs	33	25	24

Note: N=the number of States that regulate the type of facility.

Of the States surveyed, six States (**CT, GA, OH, OK, TX,** and **WA**) require centers to report serious injuries and deaths. **North Carolina** requires centers to report when a child receives medical treatment as a result of an incident occurring in child care, and **Florida** and **Utah** do not require the reporting of serious injuries or deaths (NCCCQI, 2013a). Eight of the nine States interviewed also require programs to maintain documentation of serious injuries and fatalities.

In addition to reporting to the licensing agency, most States collect information about child deaths through a child death review process; however, licensing agencies’ involvement in this process varies by State. **FL, GA, NC, OH, OK, WA,** and **UT** licensing agencies report information about child deaths to a state review board within their respective States. **Texas’** licensing agency reports fatalities that occur in child care programs to the National Center for Child Death Review only if they involve child abuse, neglect, or exploitation. **Utah’s** monthly review of child

² In the NCCCQI and NARA reports, as well as in this report, the District of Columbia is included in state counts and not listed separately.

fatalities in the State includes those that occurred in child care programs. A team including doctors, the Medical Examiner, and police, completes the review, issues findings, and may make recommendations for counseling and other forms of support. The licensing agency determines whether any violations of licensing rules occurred and takes appropriate enforcement actions.

State Systems for Tracking Serious Injuries and Fatalities

Beginning in Fiscal Year 2012, the State and Territory CCDF administrators submitted to the Office of Child Care their first annual Quality Performance Report, which requests data on health and safety indicators including injuries and fatalities in child care settings. The data for FY 2012 indicate the following:

- Twenty-nine States and Territories reported a total of 9,058 injuries occurred in child care settings;
- Twenty-four States and Territories reported that the data were not available; and
- Three States and Territories reported that no injuries occurred.

Quality Performance Report data for FY 2012 also indicate that:

- Twenty-eight States and Territories reported a total of 97 deaths occurred in child care settings;
- Ten States and Territories reported that the data were not available; and
- Eighteen States and Territories reported that no fatalities occurred (HHS, 2013).

An interesting finding from these data is the large number of States and Territories that are unable to report this information. It can be assumed that these jurisdictions either do not require providers to report injuries or fatalities to the licensing agency or they do not have the data systems in place to track the information.

Some of the States interviewed for this report do have data systems in place, while others are working on building capacity. For example, **Utah**, **Ohio**, and **Georgia** use automated systems to track serious injuries and fatalities in child care. **Georgia's** licensing database captures all reports that are categorized as Category 1, defined as serious injury and including death, abuse, accident, injury, and missing child. The agency can run reports by intake type and general category and maintains an adverse action executive summary for each facility. This offers the ability to track all adverse actions (including serious injuries and fatalities) tied to a facility. Both **Oklahoma** and **Texas** are developing the capability, within their data systems, to automatically track serious injuries. **Oklahoma's** new system will also include the tracking of child deaths. In **Texas**, however, fatality investigations are entered into the system that tracks child abuse and neglect and the licensing database. Work is underway so that the child abuse database will automatically inform the licensing database.

While not one of the surveyed states, it is worth noting that the **Colorado** licensing agency launched a web-based Injury Reporting System in July, 2014 that allows each licensed program in Colorado to submit reports online. In the past, programs manually filled out a form for each injury and submitted it to the state licensing agency by mail, email or fax (Rosa, 2013).

Common Causes of Serious Injuries and Fatalities

The States surveyed for this report identified the most frequent types of serious injuries reported (according to each State's definition of serious injury). Playground accidents account for the majority of serious injuries in **Utah** and **Texas**. Although **Washington** does not have a centralized data system for injury reporting, licensing personnel reported that falls were among the most frequent causes of serious injuries. Most serious injuries in **Florida** result from children left in vehicles. These informal reports are consistent with national data on child injuries and fatalities.

Of the States surveyed, seven of nine reported SIDS or Sudden Unexpected Infant Death (SUID) as the most common cause of fatalities in child care programs. According to the Health Resources and Services Administration, half of the approximately 4,600 sudden infant deaths each year in the United States are determined to be caused by SIDS, followed by accidental strangulation or suffocation in bed, a potentially preventable cause (HRSA, 2011). Children in child care, as reported by the States surveyed, have also died from asphyxiation, physical abuse, communicable disease, genetic disorders, and drowning.

States' Use of Available Data

States base rule changes, inspection procedures, and training for licensing staff and providers on serious incident data. **Texas**, for example, strengthened playground rules in response to numerous playground injuries. In response to the death of 10 children in unregulated care in 2005 and eight children in 2004 in illegal child care, they launched a program to reduce the number of illegal child care operations by educating providers and parents about choosing regulated care. This work follows its successful campaign—"Don't Be in the Dark about Child Care"—to discourage parents from placing children in unlicensed child care.

Georgia has made considerable investments in researching and responding to serious incidents. The State strengthened transportation-related rules and enforcement strategies in response to an analysis of data on injuries. When a child was left in a car in April 2014, Georgia responded quickly, sending letters to providers and parents, reminding them of the dangers of heatstroke in vehicles and reinforcing its transportation-related rules and repercussions of noncompliance. Georgia's Web site also includes a link to Heatstroke Safety Tips.

In an effort to identify ways to reduce injuries and fatalities in child care, **Georgia** has issued two reports on child injuries and deaths in the State. The first, *An Assessment of the Risk of Preventable Deaths among Children in Child Care in Georgia* (Carter, 2014a), analyzed deaths in child care during a three-year period from 2007 to 2009. It reported that "half ... of the 22 identified deaths were attributed to SIDS/SUID; seven were determined to be associated with previously identified medical conditions; and four were injury related." While fatalities in child care are comparatively rare, some of the SIDS/SUID deaths and all of the injury deaths could be considered to be preventable.

The second report, *Infant and Child Injuries in Georgia: A Study Comparing Injuries in Child Care Facilities with Infant and Child Injuries in the General Population* (Carter, 2014b), compares injuries that occur in child care facilities with those that occur in similarly aged children in the general population. The study found that a child younger than six years of age in the general population is about 50 times more likely to sustain an injury requiring medical services than a child in a child care facility. Findings were analyzed by injury type, cause of injury, and whether they were associated with rule violations. As a result of the study, **Georgia** plans to include the type and cause of injury in its database, using equivalent hospital discharge codes; and provide training and public awareness on the highest number of injury causes (fractures, finger crushing, burns, and allergic reactions).

Ohio's licensing office analyzes programs' incident reports for patterns related to injuries and uses the information to develop injury prevention strategies. The State publishes a chart in its annual report that shows the types of injuries reported by child care programs. In 2012, the licensing agency received 733 serious injury reports and no fatality reports.³ This same report indicated the most common injuries were bumps and bruises, cuts, and blows to the head.

³ These data do not include homes that care for fewer than seven children as they are not required to be licensed.

In response to the number of children who have died in child care from SIDS, and the recommendations from the American Academy of Pediatrics (AAP, 2011) on safe sleep practices, the number of States using these data to improve licensing rules is growing. In 2011, 42 States required center providers to place infants on their backs to sleep, and 25 States restricted soft materials in cribs (NCCCQI, 2013a). Thirty-eight States required FCC providers to place children on their backs to sleep, and 28 restricted FCC providers from keeping soft materials in cribs (NCCCQI, 2013b). NCCCQI (2013a) found that in 2011 the number of States requiring centers to place infants on their backs to sleep to prevent SIDS had increased by 18 States since 2005. Large numbers of States had also added requirements about physician authorization for a different sleep position and prohibited the use of soft bedding in cribs. All of the States surveyed for this report require safe sleep practices in child care center and FCC regulations. Several States have noticed a decrease in fatalities resulting from SIDS. **North Carolina** attributed the decrease to its required *Infant/Toddler Safe Sleep and SIDS Risk Reduction in Child Care* training, and child maltreatment training.

More States added safe sleep requirements than any other area in their child care center licensing regulations. Eighteen States added requirements for placing infants on their backs to sleep from 2005 to 2011. (NCCCQI, 2013a).

State Investigations of Serious Injuries and Fatalities

Increased attention to serious injuries and fatalities has prompted States—including several of those surveyed for this report—to expand policies to include specific guidelines on responding to injuries and deaths. States' responses often involve coordination with local and state agencies, including law enforcement and child protective services.

- **Connecticut** conducts a follow-up visit in accordance with its *Protocol for Investigating Serious Injury or Death* (available upon request from NCCCQI). The protocol was developed following a difficult, high-profile case involving the death of a child. The Connecticut staff feel the protocol has been very effective in guiding investigations and responses to serious injuries and deaths in child care programs; and
- **Florida** has a communication flowchart which provides clear guidance to the staff for reporting and responding to serious incidents (see Appendix).

The States surveyed for this report described varied enforcement responses to serious injuries and fatalities, largely dependent on the findings of the investigation. **Texas** and **Oklahoma** both take into account the provider's compliance history and response to the incident. If other children are at risk, States will most often take immediate action which may include an emergency closure.

Conducting the Investigation

Some of the States surveyed for this report have units or staff specifically designated to conduct investigations of serious incidents in child care. **Georgia** created a unit with highly-specialized investigative skills to respond consistently to all serious injuries and fatalities. **Texas'** Performance Management Operations Unit reviews the investigation report for the quality of the investigation, checking time frames and tracking fatalities, leading to improved quality and consistency of investigations. **North Carolina** has an investigative unit of about 20 staff trained in investigating child abuse, neglect, and serious injuries. **Utah** assigns an investigator in response to serious injuries and fatalities. In **Connecticut**, nurses may accompany staff designated to investigate complaints and perform follow-up visits.

The licensing agency's immediate response to a serious injury or death helps to ensure that other children are not in danger. During the investigation, the provider may be asked to close and some may do so voluntarily, especially

if a death occurred in a small FCC home. Most of the States surveyed specify a time frame within which the investigation of a serious incident must occur; this ranges from immediately to seven days.

Investigations Related to SIDS

An investigation of SIDS typically involves state agencies in addition to the licensing agency. In **Florida**, these investigations involve the licensing agency as well as child protective services, law enforcement, and medical personnel. After a SIDS investigation is completed, the licensing agency must decide what action to take based on the findings of the investigation. The action taken may vary from none, to providing additional support and increasing monitoring of the provider, or closing the facility.

Typically a SIDS death, coupled with safe sleep rule citations, results in severe sanctions, including emergency closure or revocation.

- In **Oklahoma**, a report of serious injury or death is completed and resources are provided to the facility. The agency also provides support to the licensing staff handling the incident and has psychologists under contract to provide assistance to licensing staff. The agency also provides training and other support to the providers and parents involved; and
- In **Texas**, if the provider has been determined to be responsible for the death, the license may be revoked after due process. If the death is not the result of abuse or neglect but from failure to follow safe sleep practices, corrective action may be warranted. Licensing staff can also be referred to the Employee Assistance Program for counseling and support.

Summary

Lack of a national reporting system and a common definition of injuries in child care is compounded by the fact that few States have an automated system for tracking the type and consequences of serious incidents that occur in child care programs.

Strong licensing regulations, in-depth training of licensing staff, focused provider training, and improved data collection have aided in the prevention of serious incidents in child care. The following considerations and recommendations, based on lessons learned and best practices of the States are offered are as follows:

- Licensing rules should have a clear definition of serious injury, but also include the reporting of medication errors due to the potential consequences for children;
- States should require all facilities to document and report incidents of serious injuries and fatalities to the licensing agency within a specified time frame;
- All States should adopt strong state licensing requirements on safe sleep practices including mandated provider training. The SIDS prevention actions required of U.S. Air Force child care programs reduced annual deaths from an average of six per year to almost none. (B. Schmalzried, personal communication, December 2013). These requirements can serve as a model for States. National information about infant deaths, as well as the information reported by the States interviewed for this report, suggests that all States should require providers to follow and ensure the enforcement of safe sleep practices;
- States should ensure that safe sleep practices are required of small FCC homes, and information is provided to license-exempt providers. Automated data systems, enabled to track serious incidents, can provide valuable data on how best to reduce and prevent serious injuries and deaths;

- States should regularly review and assess their regulations, enforcement mechanisms, and other policies addressing health and safety, and make necessary changes, in light of any reported serious child injuries and deaths occurring in child care settings; and
- States should share their forward-thinking initiatives in investigation protocols, data system design, provider support initiatives, and other best practices in reducing serious injuries and fatalities.

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Appendix

Communication Flowchart for Incident Reporting - Child Care

