2025

A Review of Childcare Related Deaths in Virginia

2018-2024

A report from the Virginia State Child Fatality Review Team

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Executive Summary

The State Child Fatality Review Team (the Team) was created in 1994 to establish a systematic review process of child deaths in Virginia. The Team collects data and conducts these reviews on specific phenomenon that result in child fatalities in the state. Past review topics have included drowning, suicide, hot car deaths, and unsafe sleep associated infant deaths. For the review cycle occurring during 2023-2024, the Team elected to look at child fatalities that occurred in both licensed and unlicensed daycare settings. Of the five manners of death, Accident, Homicide, Natural and Undetermined were represented in this cohort; there were no suicides.

In July 2021 oversight of childcare in the state was transferred from the Department of Social Services to the Department of Education. This coincided with a wave of return to work in the wake of the COVID-19 pandemic closures, resulting in an increased need for childcare. As a result of these changes the Team felt a review of the deaths that occurred in daycare settings was timely, and the recommendations could provide meaningful insight to the individuals and agencies responsible for the safety and wellbeing of the states children.

Key Findings: Childcare Related Deaths in Virginia

- One third of the fatalities occurred in children under the age of four months; increased parental leave could potentially save lives
- Parents often reported they misunderstood or felt misinformed about how to appropriately evaluate daycare providers, how to complete background checks, or lacked clarity on the laws of the state
- Several parents reported concerns, however, were unable to change providers due to location, economic factors, or lack of available spaces
- Family day homes are an integral part of Virginia's childcare system; however, these providers often lack basic skills such as CPR and safe sleep education
- Children of parents with non-traditional working hours such as health care providers, first responders, military members and shift workers have substantial difficulty with locating safe and affordable childcare

Introduction

According to available research, one of the biggest challenges facing American families is the availability of safe, affordable childcare. In 2023, 67% of married couples in the United States with children under the age of eighteen were dual income households (Bureau of Labor Statistics, 2024). In single parent households maintained by fathers, over 86% of these heads of household were employed, and in single parent households maintained by mothers nearly 77% of the heads of household were employed. The challenge of finding suitable childcare for these families is daunting; a 2023 brief by the Women's Bureau of the Department of Labor Statistics found that childcare for an infant consumes between 24% and 71% of household income in single parent households (Landivar, Graf, & Altamirano Rayo, 2023). Parents are frequently forced to prioritize costs, as well as several other factors when selecting childcare.

Child Care in Virginia

A 2022 review by the Joint Legislative Audit and Review Commission (JLARC) revealed that 1.13 million children in Virginia aged twelve and under, require at least part-time childcare (Joint Legislative Audit and Review Commission, 2023). Of these, about 55% are of school age children and need only part-time care, while the remaining 45%, or roughly 500,000 children, require full-time daycare throughout the year. After evaluating available childcare spaces, JLARC found that available daycare spaces were 140,000 short of the needs of Virginia families.

Furthermore, the Department of Housing and Urban Development categorizes 88% of Virginia as rural (Rural Virginia Initiative, 2022)[1]. The population distribution in Virginia is consistent with national distribution patterns; 26% of the state's population lives in areas considered rural. These areas are more likely to be considered childcare deserts, defined as either having no available childcare or at least three children in need of childcare for each available spot; and are disproportionately impacted by the lack of childcare (National Advisory Committee on Rural Health and Human Services, 2023). In this cohort, all the families that lived in rural environments using the USDA Rural-Urban Continuum Codes categorization also lived in areas of scarce childcare supply according to the Center for American Progress Child Care Deserts interactive map (United States Department of Agriculture, 2023; Center for American Progress, 2020).

Childcare standards vary significantly across the nation, and in Virginia, both licensed and unlicensed settings are legally permitted to provide care. Until July 2021, the Department of Social Services (DSS) oversaw the regulation of this sector. The responsibility for licensing and supervising childcare providers was transferred to the Department of Education (DOE). This shift was designed to enhance early childhood education and better prepare Virginia's children for kindergarten, aligning with the DOE's broader mission.

[1] The Virginia State Office of Rural Health uses the US Office of Management and Budget definition of rural, which considers economic, transportation, and institutional networks to categorize areas. Rural areas are those that do not meet the criteria for a Metropolitan Statistical Area.

The Code of Virginia[2] provides for several levels of legal childcare within the state. *Family day homes* are those where services are provided within the home of the owner/ operator, and may be registered or licensed, but are not required to do so if caring for 4 or fewer children. *Child day centers* are facilities for caring for two or more children in an establishment that is not the home of the owner/ operator, and these are required to be licensed in with the Department of Education, Child Care Health and Safety (CCHS) division. Religious institutions that meet specific requirements are exempted from the licensing requirement. Furthermore, four localities in the state impose additional requirements to operate within their district limits. These are Arlington County, Alexandria County, Fairfax County, and the city of Norfolk[3].

The Division of Child Care Health and Safety also authorizes *Family Day Systems.* Family Day Systems are privately operated enterprises that provide organizational structure for member family day home providers. The family day system organization is empowered by the CCHS to oversee all licensing, supervision, and technical assistance to their member providers. These owner/ operators may care for up to nine children and are subject to the same rules and regulations as other licensed providers in the state, however supervisory authority has been granted by the Child Care Health and Safety division to the Family Day System organization, and corrective action, if needed, is managed entirely by the organization[4].

Although all childcare providers in Virginia are legally required to obtain a business license, this is separate from a license issued by the DOE to provide childcare. For the purposes of this report, licensed facilities are those that have a valid DOE issued license. Licensure in the state includes educational requirements, as well as specific facility requirements and child-to-caregiver ratios. Not all providers are required to be licensed; as described above, home daycare with four or fewer children is legal in the state and may operate with no oversight from CCHS. These homes do have the option to register with the DOE, which may make them eligible for subsidies as well as training resources.

As of May 2025, there were 6,517 child day programs recognized by the CCHS; this includes both center and home-based programs. Of these, 1,942 are home-based programs, and 191 of these are voluntarily registered family day homes. Voluntarily registered programs constitute 2.93% of the total child day programs identified by the CCHS, or 9.84% of home-based programs known to the CCHS. There are no estimates on the number of unlicensed and unregulated home-based programs operating in the state.

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[2] https://law.lis.virginia.gov/vacode/title22.1/chapter14.1/

[3] Arlington County: https://www.arlingtonva.us/Government/Departments/DHS/Child-Family-Services/Child-Care ; Alexandria County: https://www.alexandriava.gov/child-care/registration-requirements-standards-for-family-child-care-homes ; Fairfax County: https://www.fairfaxcounty.gov/neighborhood-community-services/ceps/become-a-family-child-care-provider#:~:text=In%20Fairfax%20County%2C%20anyone%20who,by%20the%20state%20of%20Virginia. ; Norfolk: https://www.norfolk.gov/5146/The-Licensure-Process#:~:text=Norfolk's%20Department%20of%20Human%20Services,the%20provider's%20own%20children%20and

[4] https://www.childcare.virginia.gov/providers/program-types/licensed-family-day-system

A review of child fatalities in Virginia over a five-year period from 2018 to 2023 by Virginia's Child Fatality Review Team (the "Team") revealed that more than one child per month dies while in the care of a babysitter or childcare setting. The majority of these fatalities occurred in childcare settings where the provider offered paid services on a regular basis. Considering the recent transfer of oversight from the Department of Social Services (DSS) to the Department of Education (DOE), the Team decided by consensus to conduct a comprehensive review of child fatality cases within daycare settings. With the new agency oversight and corresponding shift in focus in alignment with the DOE mission, the Team felt this was a good opportunity to review these fatalities and develop recommendations. This review involved a retrospective examination of the circumstances surrounding each fatality, focusing on a systems perspective to identify service gaps and opportunities for improvement. The findings are addressed in the Team's recommendations.

Methods

Case selection for this review began with a review of all child fatalities that fell within the jurisdiction of the Office of the Chief Medical Examiner (OCME) between the years of 2018 and 2023. This review was limited to decedents aged five years and under; the cases were reviewed through the Virginia Medical Examiners Data System, or VMEDS. All causes and manners of death were reviewed. Cases in which the decedent was not a Virginia resident were excluded; in addition, one case was excluded because the child's injury occurred outside of the state of Virginia, although the death occurred within the state's borders.

Cases in which the OCME documentation clearly indicated that the child was in the care of a parent or single episode babysitter were excluded. If the caregiver was not noted the OCME paper file was examined for clarification. This resulted in the potential inclusion of 59 child fatalities. Documents on these cases were collected in compliance with the State Child Fatality Review code § 32.1-283.1[5]. After further review an additional 15 cases were excluded. The reasons for exclusion included residency status (2), death occurred during a single incident of childcare/ babysitting (10), death occurred under the supervision of a nanny or paid in-home nurse (2) and a single case in which the childcare arrangement terms could not be determined.

For the final review cycle, forty-four cases were included. These were cases in which the child was a resident of Virginia, was injured in Virginia, died in Virginia, and the case was within the jurisdiction of the OCME. The childcare was provided at a site other than the child's home, on a regular basis and there was a financial arrangement between the parents/guardian and the provider for services rendered.

Sources for each case were identified through the medical examiner's case files, and included law enforcement, medical care providers, social services, Department of Education (DOE), and court records related to both the child and their caregivers, as permitted by the Code of Virginia. This documentation was carefully reviewed, and deidentified case reports were compiled by the team facilitator for the confidential Child Fatality Review Team (CFRT) meetings, which are held six times per year. The Team is comprised of members appointed by the

[5] https://law.lis.virginia.gov/vacode/title32.1/chapter8/section32.1-283.2/

Governor's office, as well as representatives of state agencies, as defined in the code, and subject matter experts who may be appointed by the team chairman. The Team is chaired be the Chief Medical Examiner. The Team is multidisciplinary and composed of representatives from agencies across the state, ensuring a diverse range of expertise and regional perspectives. While not mandated by the code, the DOE Director of Child Care Health and Safety was included as an ad hoc committee member for this review cycle to provide additional expertise. Each meeting the Team discussed the circumstances of each case, responded to standardized poll questions, and had the opportunity to provide recommendations. The Team evaluated the cases using a systems approach; this involves a holistic approach and acknowledges that in each case there are several contributing factors that are interconnected and result in the outcome. This method of review involves considering the family and their circumstances within the context of their environment and the systems they interacted with as a means of identifying contributing factors and opportunities for intervention to prevent future deaths. The review cycle began in March 2023 and case review was concluded January 2025.

In total, 43 of the cases were reviewed by the Team. It is a requirement that all cases to be reviewed have been finalized by involved agencies such as Child Protective Services and court systems. At the time of the final review meeting one case had yet to be resolved through the court system; as the case had not yet gone to trial as of the January 2025 review meeting and was not discussed by the Team. Demographic information from this case was included in final data collection and analysis.

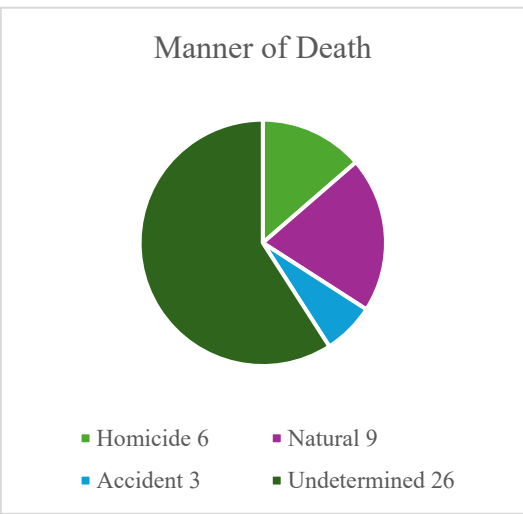
Results

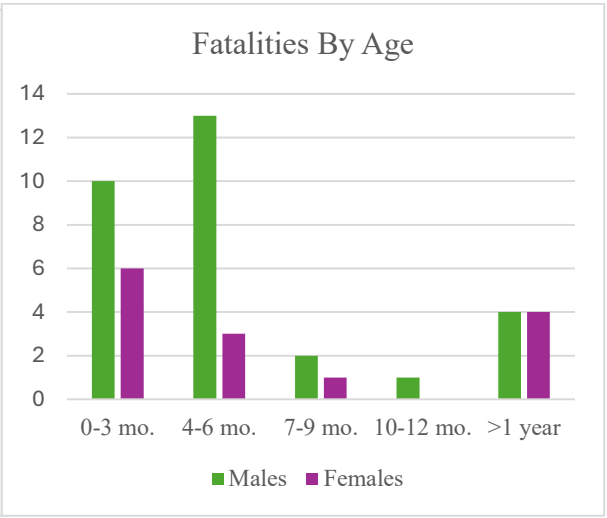
Quantitative Data

Unsafe sleep was the most common cause or contributing factor to death and was identified in 28 of the 44 cases (63%). Standardized safe sleep recommendations are that infants sleep alone on their back, in a crib or bassinet without blankets, pillows, or other items until the age of 1 year (Safe to Sleep, 2025). Common unsafe sleep environments included sleeping in an adult bed; sleeping with others including other children; pillows, blankets or toys in the sleep space; and positioning the infant on their side or stomach for sleep. Unsafe sleep is a leading cause of death among infants[6]; these deaths are more common in males and nearly two-thirds of these occur between the ages of 1-4 months (4). This review was consistent with the national data, 18 (64%) of the unsafe sleep related fatalities were males and 19 (67%) of the deaths occurred in infants less than 5 months old. In total, 23 of the 28 cases (82%) in which unsafe sleep was a factor involved infants under 6 months of age. Most of these deaths were assigned

[6] National data uses the term SIDS (sudden infant death syndrome) to classify sudden infant deaths, typically as a diagnosis of exclusion when no contributing factors are found. To better capture cases with contributing factors like unsafe sleep, the term SUID (Sudden Unexplained Infant Death) was introduced, encompassing SIDS and other unexplained deaths. Inconsistent use of these terms persists nationally, often due to varying levels of training among coroners and medical examiners. Unlike jurisdictions that rely on coroners, Virginia uses only board-certified forensic and pediatric pathologists, who reserve the term SIDS for true diagnoses of exclusion and use SUID when risk factors are present. No SIDS cases were identified in this review.

the manner of death as Undetermined, although some of these cases were assigned the manners of Accidental or Natural.[7]





Two-thirds (n=30) of the children who died were male, one third (n=14) were female. Twenty-eight of the children were white, nine were black, two were Asian, and three were 2 or more races. Six of these children were identified as Hispanic, thirty-eight were not. This is roughly consistent with the population statistics for Virginia (US Census Bureau, 2023).

Racial Demographics

Race	Virginia Unsafe Sleep Fatalities	Virginia Total Population by Race	Rate by 2023 Census Data VA children 0-5 (per 1000)
Asian	4.5%	7.4%	.052
Black	20%	20%	.077
Two or More Races	9%	3.5%	.078
White	66%	68%	.096
Hispanic	13.6%	11.2%	.059

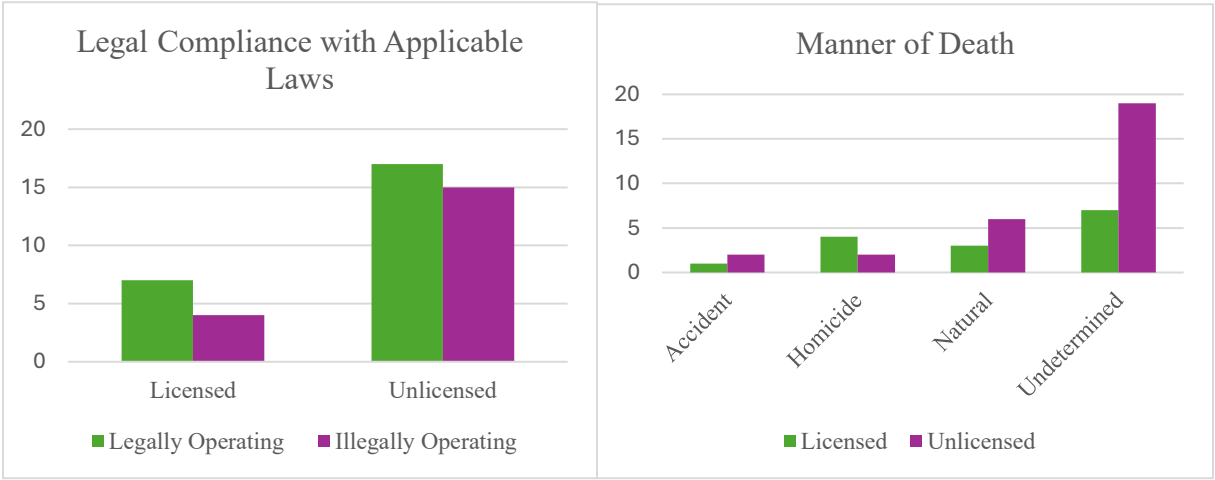
Only twelve of the daycare sites were licensed, thirty-two were unlicensed. At the time of the fatality, five of the licensed facilities were in violation of the law, while seven of the licensed daycares were compliant. When considering applicable laws for both family day homes and licensed centers, nineteen of the owner/ operators were in violation of the law, and twenty-four were operating within the legal parameters for their situation. All the primary caretakers

[7] There are five manners of death on a standardized death certificate, they are: Accident, Homicide, Natural, Suicide, and Undetermined. This is a legal determination based on both the cause of death and relevant circumstances at the time of the death.

who were responsible for the child at the time of death were female, although in one licensed facility one of the four supervising adults present at the time of death was male.[8]

In six of these cases, the manner of death was determined to be homicide; four of these homicides occurred in unlicensed homes, while two took place in licensed facilities. Of the six cases, four involved owners/operators who adhered to the regulations for daycare environments, while the other two were operated illegally by unlicensed individuals. In all homicide cases, the cause of death was blunt force trauma inflicted by the daycare provider.

For the remaining cases, the most common manner of death was classified as "Undetermined." Nine cases were identified as natural deaths, with three occurring in licensed facilities. Of those three, two were found to be in violation of licensing laws. Three deaths were ruled as accidental, with one being a non-sleep-related fatality in a licensed facility, and two resulting from unsafe sleep practices in unlicensed and unregistered family day homes.



Systems Review

The Team reviews these fatalities from a systems perspective which examines all the interactions the child and their family or caregivers had with systems, organizations and institutions and how the intersectionality of these systems may have impacted the outcomes in the life of the child (Hengelbrok, Modell, Cheetham and Nyce, 2019). When reviewing a child's death, it's natural to immediately focus on the individual who directly caused or failed to act in a way that led to the fatality. However, this perspective is limited and overlooks potential solutions to reduce child deaths in the future. No recommendation or policy change can intervene at the final moment to save a child's life. Instead, meaningful intervention occurs by examining the systems the family engaged with leading up to the tragedy. Every interaction a child or family

[8] The most common statutory violation for unlicensed and unregistered family day homes was exceeding the number of children in care. The law states unlicensed homes may take care of no more than 4 children total. Other violations included failure to notify parents of unlicensed status and lack of a business license. Violations for licensed facilities included violations of child to caregiver ratios. Each of the homicides included multiple violations of numerous laws.

has with these systems presents an opportunity to identify risk factors or alter the family's trajectory, ultimately creating the potential for improved outcomes.

The multidisciplinary composition of the team is important to the systems perspective. Representatives can describe the challenges and opportunities within their respective disciplines that may have been helpful or resulted in barriers to these families. This provides greater understanding and cooperation among all team members and ideally facilitates greater interagency communication and cooperation. At the conclusion of the review during the recommendations phase, organizational representatives have the opportunity to provide input on how to craft the recommendations in such a manner that they are achievable and relevant to the organization's operational structure.

Systems Factors and Childcare Decisions

These systems factors shape outcomes by influencing the choices parents make in seeking childcare. In eleven of the cases the parents' non-traditional working hours impacted the childcare choice. Individuals who work non-traditional hours in our review were military service members, law enforcement, hospital-based healthcare, students, and shift workers. These parents required childcare providers that could accommodate early drop-offs, late pick-ups, weekends and overnight hours. None of the licensed facilities included in our review offered extended hours that could accommodate these families.

Proximity to home or work was another significant factor for families. We found that the average distance from home to childcare was 8.6 miles. This data was combined with childcare availability data to identify families that lived and worked in communities in which childcare was either adequate, limited, or scarce (Center for American Progress, 2025). Families residing in areas with adequate or limited childcare on average traveled slightly over 4 miles to their childcare provider, while families living in areas with scarce childcare resources traveled on average 11.8 miles. The additional time and resources in these areas were an influential factor as parents must consider work schedules, daycare operating hours, policies on late pick-ups, the needs of others in families with multiple children, and accessibility in case of illness or emergency.

Nine of these fatalities were determined to be natural, in most of these cases the child died of an acute illness like pneumonia or COVID-19. Several of the unsafe sleep cases which had an Undetermined manner of death also had an element of acute illness identified at death. Three of these occurred in licensed facilities, although all three were in violation of the terms of the license on the day of death[9]. This brings up several considerations. Licensed facilities providing safe care have policies related to illness in order to protect all children. Unlicensed day homes and licensed facilities that are not strictly adherent to policies may be more inclined to accept these children as parents often cannot afford to stay home from work, and owners/

[9] These facilities had multiple violations on previous inspections, on the day of the fatality violations included exceeding child to caregiver ratios and using unsafe sleep or childcare practices.

providers are dependent on the income. This can lead to a seriously ill child in an environment with limited supervision.

Discussion and Recommendations

At the conclusion of each case review the Team proposed recommendations based on the specific risk and systems factors associated with the case. At the conclusion of the cohort review, these recommendations were compiled and analyzed using both quantitative and qualitative methods, with several recurrent themes identified. These recommendations were then organized by impacted agency and discussed by the Team to ensure they represented the consensus of the group. Recommendations were then parsed out to individual team members who represent the stakeholder groups identified in the recommendations for further refinement. These recommendations go through the refinement process until the Team agrees on a final draft.

The recommendations do not provide specific instructions on how they are to be implemented, as in each case there may be agency policies or legislative requirements to contend with, and this extends beyond the scope of the Team. Rather these recommendations are based on recurrent gaps in services or processes identified by the Team throughout the course of the entire review, and it is up to the respective agencies, legislators and community stakeholders to consider what changes are feasible within their operational boundaries, and the best mechanisms for implementation.

Throughout this review the Team determined that families had to balance several competing priorities in making childcare decisions. The influential factors included proximity of the provider to home or work, cost, operating hours, availability, and environment. The Team concluded that increased parental leave or work flexibility could potentially save lives, as more than one third of the fatalities occurred in infants under the age of 4 months, which is the age at which infants are at the greatest risk for an unsafe sleep death. Extended parental leave would delay the need for childcare for this vulnerable age group. In our review, twelve of the children, or 27%, were in daycare for one month or less.

While some parents felt more secure with larger licensed facilities, other families preferred the more familiar environment of a family day home. Parents frequently bypassed vetting these providers, whether licensed or unlicensed, including background checks, investigating licensing status or violations, or verifying references. The Team could not determine in all cases why this critical step was missed, although parents who used family day homes consistently reported that they misunderstood or felt they were misinformed about the distinction between a childcare license and business license. In more than one case, the parents expressed to investigators after a fatality that they were aware that something was “off” however due to circumstances they were not able to make other arrangements or were in the process of making other childcare arrangements at the time of the incident.

Family day homes are a vital component of Virginia’s childcare system and provide a substantial amount of childcare, most often in caring and safe home environments. These providers meet the needs of families in rural areas and are frequently the providers that help to accommodate non-traditional work schedules. The Team found the cost and requirements of

licensing to be prohibitive to these providers and not necessary in homes operating within the currently legal boundaries. Although not currently a requirement, the Team recommended registration with the Department of Education for providers who are not currently required to be licensed because they care for four or fewer children. The Team recommended registration to include basic education on safety including safe sleep and CPR training as well as a basic environmental safety inspection annually. Ideally this minimal level of oversight for family day homes can provide support and resources such as food or fee subsidies and education for the providers and increased safety for parents. Although there is an exemption from licensing for religious organizations, the Team recommends these facilities also at minimum be required to complete safe sleep education for staff.

Parent education was frequently a topic of case discussions throughout the review. The Team found through these cases that parents were often not aware of the laws of Virginia regarding capacity limits for providers, the distinction between business and childcare licensing, or even what to look for in a provider when seeking childcare. The Team recommends that agencies such as the Department of Education or Department of Social Services, and well as any health care provider or community organization that engages with new parents explore avenues to increase education for new parents and soon-to-be parents on how to select quality childcare as well as the state laws governing this industry.

Healthcare providers are an important resource for soon-to-be and new parents, and education on how to identify a quality childcare provider could be provided through these contacts. This is particularly true when considering medically complex children, as finding appropriate childcare can be even more difficult and requires good communication and cooperation between the parents and the caregiver.

The Team found that communication between law enforcement and Child Protective Services at times was deficient. One identified cause for this deficiency was a lack of understanding by law enforcement of the laws governing childcare and the ability of CPS to aid families and providers in the wake of a fatality. The Department of Criminal Justice Services (DCJS) developed a training protocol for law enforcement and CPS workers following a previous review to improve the quality of child fatality investigations which emphasizes the importance of interagency cooperation. The Team has recommended that the Department of Criminal Justice Services incorporate a daycare module into their Child Death Investigation Protocol Training.

To address the childcare shortage in rural communities, partnerships with local churches and community organizations can be a key strategy. These collaborations can help expand available spaces and provide resources where they are most needed. Additionally, high schools could serve as valuable assets by offering education on childcare safety and supporting young mothers. Exploring and supporting non-traditional childcare solutions should be prioritized to effectively meet the diverse needs of rural communities.

The military has a large presence in Virginia, particularly in the southeastern region. Despite the round-the-clock responsibilities of military personnel, the few military childcare

facilities available operate only during traditional business hours. Additionally, wait times for a spot may be more than a year, with longer wait times for infant care. The military also has a program for home care in military housing, although this is limited to 2 children under the age of 2, or 6 children under the age of 8 and has unique certification requirements and restrictions separate from state programs. While this may help address the need, the work hours required for military service members, frequent change of duty stations for both providers and families seeking childcare, and cost of childcare result in a particularly challenging childcare landscape for military families.

Conclusions

Families in Virginia, like those across the nation, are experiencing challenges in locating safe, available, and cost-effective childcare. Families in rural communities, lower income families, and those that work non-traditional hours have even greater difficulty in finding a childcare provider. While many who provide this valuable service in the state are compassionate and conscientious caregivers, they may lack the knowledge necessary to keep these children safe. This includes a thorough understanding of safe sleep practices and CPR certification. After an extensive two-year review of child fatalities that occurred in both licensed and unlicensed childcare settings in the state, the Team developed a list of 34 recommendations listed in Appendix III for consideration. We encourage legislators, community groups, health care providers, state agencies, and other stakeholders who have interactions with families depending on childcare to consider these recommendations and take action to support the most vulnerable in our state.

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Appendix I: Definitions

Licensed Child Day Centers: Child day programs that provide care for two or more children under the age of 13 in a facility that is not the home of the provider or any of the children, for a period of less than 24 hours. These are licensed by the DOE.

Licensed Family Day Homes: These providers operate childcare in either the home of the children or the provider for a period of less than 24 hours. A license is required for anyone caring for more than 4 children. Those caring for 4 or fewer may choose licensure although it is not a requirement unless all 4 children are under the age of two; including the providers own children or children who live in the home.

Licensed Family Day Systems: Organizations that are licensed by the DOE to provide technical assistance, licensing, inspection and supervision to member family day home providers. Family day systems are licensed by the DOE to provide all services and supervision to their members normally provided by the DOE to licensed providers.

Local Ordinance Homes and Centers: Four jurisdictions in Virginia- Arlington County, Alexandria City, Fairfax County, and Norfolk City- maintain a separate regulatory body to approve family day home and center-based programs. To receive subsidies, these facilities must comply with annual health and safety inspections by the DOE.

Religiously Exempt Child Day Centers: Although these facilities do not require licensure, they are subject to inspection to ensure code compliance and must adhere to all requirements if participating in subsidy programs.

Voluntarily Registered Family Day Homes: Voluntary registration is an option for family day home providers who are not legally required to be licensed; however, these providers are eligible for certain childcare provider subsidies if registered.

Appendix II: Poll Questions

Poll Questions

The poll questions were launched at the conclusion of the discussion for each case, then results shared with team and discussed to build consensus and develop additional recommendations.

 # 1 What factors in the child's household may have led to the selection of this daycare/ childcare provider:

- Economic factors
- Non-traditional work hours
- Availability of care (i.e., proximity to home or work, available spaces)
- Education/ Knowledge of licensing regulations (chose licensed facility because it was licensed; did not understand difference between business and childcare license; made assumptions based on lack of understanding of VA licensing regulations)
- None
- Unknown

 # 2 System factors that may have contributed to the death of the child in daycare/ childcare environment:

- Unlicensed/ Unregulated
- Deficits in regulatory oversight or enforcement
- Lack of clarity of regulations (i.e., kinship relationships, inconsistencies between state and locality regulation, regular care vs. "drop offs")
- Facility hours
- Compliance with policy (either state laws or provider policies)
- None
- Unknown

 # 3 Were there characteristics of the childcare provider contributed to an unsafe environment:

- Education (safe sleep, laws)
- Staffing issues
- Space or Equipment issues
- Knowledge of current best practices
- None
- Unknown

Was this death preventable?

- Yes
- No
- Unsure

Poll #1 What factors influenced the parents' daycare choice- money, location, hours, more "homey" than a facility? The answers to this will vary, and may be subjective or difficult to discern, but in many cases, there will be clues in the records.

Poll #2 Was there some component(s) of a larger system that led to that child being in that childcare at that time –how was a violator still operating? Were children here because parents who worked non-traditional hours had limited options? Did the parents understand a business license vs. a childcare license?

Poll #3 Did the provider know what the safe sleep rules were? Was she CPR certified? Were there enough adults to supervise the children? Was the environment safe? Was there a background check?

Appendix III: Recommendations

Recommendations were developed by the Team and were abstracted from the discussion following each case presentation. At the completion of the cohort review, the recommendations were compiled. The recommendations were reviewed by the Team as a whole to ensure they represented the consensus of the group. Next agency representatives had the opportunity to vet recommendations specific to their area of expertise to assess feasibility and further refine the language. Finally, the Team, as a group, reviewed and approved the final recommendations.

The Team makes the following general recommendations:

1. Employers and lawmakers should encourage increased parental leave or increase flexibility for new parents to reduce the need for infant daycares
2. Explore opportunities for community partnerships to reduce the cost of obtaining licensure such as low cost or free CPR training
3. Address shortage of daycare in rural areas- find a way to provide incentives for safe and legal daycare in rural communities- explore options to empower existing infrastructure such as churches to help address needs
4. Provide education for families on the difference between daycare licenses and business licenses
5. The military should have more childcare, with flexible hours to accommodate military schedule
6. Explore options and incentives for providers to accommodate non-traditional work schedules
7. Multilingual education should be provided for parents during the prenatal/perinatal period on daycare laws and what to look for in a safe childcare provider
8. Schools could be a resource to provide some childcare, may help assist with teenage pregnancy as well- training for students in childcare and meet community needs
9. Coordination between daycare licensing and business licensing would be beneficial to ensure childcare licensing is aware of business licenses and vice versa
10. Explore new ways of communicating safe sleep and daycare information through doulas, community organizations, prenatal providers, birthing classes, parenting classes, etc. Safe sleep organizations could provide information on how to find quality daycare.
11. Develop a form or check list of some sort for parents to check daycares, how to background check providers

The Team recommends that the DOE consider the following recommendations:

1. Should consider requiring registration for all in home care- could include basic inspection, CPR, safe sleep training and permit random checks for compliance, if watching more than 1 child or watching children more than 1 day per week.
2. Always requiring one person on premises with CPR training during business hours
3. Consider options for various waivers- i.e., if fatality is accidental allow an individual to pursue licensing

4. Consider code change allowing regulating agency to administer a waiver for individuals who may not have a perfect record- i.e. non-violent criminal history with >10 years "clean" record
5. Consider requiring that everyone on the premises must be able to pass a background check
6. Providing safe sleep education
7. Greater transparency/ oversight of Family Day Systems
8. Work to improve coordination between DOE and local jurisdictions that regulate childcare (i.e. Alexandria, Fairfax)
9. Explore options to make licensing more affordable, easier for in-home providers
10. Permit or require undesignated epinephrine pen in licensed daycares and provide training on identification of allergic reactions, as well as safe and appropriate use of the epi-pen.
11. When considering licensed daycares with pool access: there should be a requirement that the supervisors be able to swim *in water greater than wading depth*
12. Provide education/ clarification of the regulation related to what does or does not count as a familial relationship for childcare purposes
13. Remove immigration status from licensing requirements- may encourage licensing which improves safety and can reduce the deficit of licensed childcare spaces in some communities
14. Provide increased monitoring for providers
15. Require and provide safe sleep education for religious exempt providers

The Team recommends that Health Care Providers consider the following recommendations:

1. Pediatricians could provide information during early pediatric visits on how to find daycare, what to look for
2. Include education at ED/ free standing clinics for underinsured; find ways to reach undocumented families
3. Make sure providers that care for medically fragile children are able to provide appropriate care

The Team recommends that CPS consider the following recommendations:

1. Work to establish better communication between Law Enforcement and CPS in cases of fatalities
2. CPS should hold onto records longer; could affect licensing in the future

The Team recommends that Law Enforcement and Commonwealths Attorneys consider the following recommendations:

1. Work to establish better communication between Law Enforcement and CPS in cases of fatalities
2. Receive education on basic daycare laws
3. DOJ should include daycare information/ daycare death investigation best practices information into child death investigation protocol training

Appendix IV: State Child Fatality Team Members

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