



Minnesota Department of Human Services

Review of Child Deaths in Minnesota Licensed Family Child Care Homes

January 2002-August 2012

August 2012

Child Mortality Review Panel

Children and Family Services Administration

Minnesota Department of **Human Services**

This information is available in alternative formats to individuals with disabilities by calling 651-431-4671. TTY users can call through Minnesota Relay at 800-627-3529. For Speech-to-Speech, call 877-627-3848. For additional assistance with legal rights and protections for equal access to human services programs, contact your agency's ADA coordinator.

Review of Child Deaths in Minnesota Licensed Family Child Care Homes

The Minnesota Child Mortality Review Panel examines child deaths and near fatal injuries that occur in families known to the social services system, or where maltreatment caused or contributed to a fatal/near fatal incident. The Minnesota Child Mortality Review Panel (“Panel”) also reviews deaths that occur in facilities licensed by the Department of Human Services. The Panel reviewed individual cases involving deaths that occurred while in the care of a licensed child care provider and noted an increase in deaths in licensed child care since 2006. In May 2012, a subcommittee of the Panel was convened to further study deaths in licensed family child care homes and make recommendations for improvements to child safety in licensed child care to the commissioner of Human Services.

The Panel’s Subcommittee on Child Care Issues included members of the Child Mortality Review Panel, as well as, Department of Human Services’ administrators with knowledge of child care and child care licensing policies. The subcommittee reviewed the aggregate data collected from the deaths in licensed child care, identified relevant state statutes and administrative rules, and reviewed best practices recommendations of the National Association of Child Care Resource & Referral Agencies and the National Resource Center for Health and Safety in Child Care and Early Education. Recommendations were developed and presented to the Child Mortality Review Panel for further input before they were approved by Panel members. The focus of the Panel’s recommendations support a licensing structure, policies and other strategies that create a safe, nurturing environment that enables a child to develop and learn. The recommendations focus on prevention of child deaths.

Data was gathered from the Minnesota Department of Human Services Licensing Division, Minnesota Sudden Infant Death Center and Child Mortality Review Panel on deaths in licensed child care facilities. Minnesota has 10,936 licensed family child care homes and 1,578 child care centers. Thirty-four percent of the child care homes have a license capacity for 10 children; forty-two percent have a license capacity for 12 children; and twenty percent have a license capacity of 14 children. The remaining four percent of the homes specializing in infant and toddler care and are licensed for five to nine children. All the deaths that occurred in family child care homes were licensed for ten or more children.

The data reveals 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.

Table 1: Deaths in licensed child care by year

Year	Deaths in licensed family child care homes	Deaths in licensed child care centers	Total deaths by year
2002	3	0	3
2003	5	0	5
2004	4	0	4
2005	5	1	6
2006	10	0	10
2007	6	0	6
2008	12	1	13
2009	8	0	8
2010	10	1	11
2011	11	0	11
2012 (as of August 1, 2012)	9	0	9
TOTAL	83	3	86

In 1994, the National Institute of Health and Human Development and American Academy of Pediatrics initiated the “Back to Sleep” campaign to educate parents and caregivers about ways to prevent Sudden Infant Death Syndrome. As a result of the campaign, the percentage of infants placed to sleep on their backs increased significantly, and by 2006 the overall rate of sudden infant death decreased 50 percent. As the result of improved diagnostic and death scene investigations regarding the cause of infant deaths, the numbers of unexpected infant deaths involving suffocation, strangulation, entrapment, and asphyxia have increased. Medical research continues to study sudden unexpected infant deaths to learn more about the triggers that increase risk for better prevention. [Pediatrics, Volume 128, Number 5, November 2011]

In 2005, the American Academy of Pediatrics issued a policy statement in *Pediatrics* describing recommendations for safe infant sleep; in 2011 the recommendations were expanded. The American Academy of Pediatrics recommends that infants be placed to sleep on their backs for every sleep to reduce the risk of sudden unexpected infant death.

<http://pediatrics.aappublications.org/content/early/2011/10/12/peds.2011-2284>

The Minnesota Departments of Human Services and Health support the American Academy of Pediatrics recommendations for safe infant sleep.

The Child Mortality Review subcommittee reviewed the National Center for Child Care, Health and Early Education standards, “Caring for Our Children.” The child care best practice standards are thorough and supported by current research in the field. Minnesota’s family child care licensing standards fall short of the national best practice recommendations. When Minnesota’s licensing standards were compared with other states using summary documents provided by the National Association of Child Care Resource and Referral Agencies, Minnesota’s policies permit greater capacity of children in family child care homes, larger child to adult ratios, fewer licensing inspections and less training.

Minnesota’s licensing regulations for child care centers requires that there is one adult responsible for four infants, without caring for other children. In child care centers, additional staff members are present to supervise the caregivers, assist in an emergency and enable them to take breaks. In family child care homes, there is often one adult caring for 10 to 12 children. The quality of family child care is essential to ensure children’s safety and healthy development.

Minnesota Rules, chapter 9502 indicates that the purpose for licensing child care homes is to ensure that minimum levels of care and service are provided, and that highest priority for the protection, proper care, health, safety and development of children is assured. Licensing standards need to strongly emphasize the vulnerability of children in care, and even at the minimum level of care, the importance of assuring a safe, nurturing environment.

Licensing requirements of providers

Minnesota’s child care licensing regulations do not require that applicants hold a high school diploma or GED. In the forthcoming “Child Care Workforce in Minnesota” report which analyzes demographic trends for the child care workforce, 64 percent of licensed family child care providers reported having a high school diploma or GED. The National Association for Child Care Resource and Referral Agencies recommends that family child care providers/teachers have a high school diploma or GED, and work toward or hold current accreditation by the National Association for Family Child Care; or hold an Associate Degree in Child Development or Early Childhood Education. The Child Mortality Review Panel recommends that family child care providers hold a high school diploma or GED, or equivalent.

A waiver could be provided for immigrant applicants for a child care license if they earned a high school diploma, GED or equivalent before moving to the United States, but are unable to provide verification of their education.

Current regulations permit a provider to hire a helper to assist in child care. A helper is defined in Minnesota Rule, part 9502.0335, as at least 13 years old but less than 18 years. The Child Mortality Review Panel recommends that this Rule be amended to require helpers to be at least 16 years old, to be consistent with national standards.

Training

License holders, caregivers and substitute caregivers must obtain specific initial training including child growth and development, first aid, cardiopulmonary resuscitation (CPR), risk reduction of Sudden Infant Death Syndrome, Shaken Baby Syndrome prevention and child passenger restraint system training in order to be licensed in Minnesota. The child growth and development training must be completed within the first year of licensure. Substitute caregivers who provide less than 30 hours in a 12-month-period are exempt from most of the training requirements, but must be trained in reducing risk of Sudden Infant Death before they care for infants. Child care helpers who assist with care on a regular basis must complete six hours of training within one year after the date of initial employment.

Reduction of risk for Sudden Infant Death and Shaken Baby prevention training are currently required in Minnesota Statutes, section 245A.50, to be completed before caring for children, and every five years thereafter. The Child Mortality Review Panel recommends that these training classes be required annually.

Training requirements are described in Minnesota Statute, section 245A.50. The statute requires that when children are present in a family child care home at least one staff person must be present who has been trained in first aid and CPR. Licensed family child care providers are often the only adult in the home, therefore they must demonstrate competency in performing CPR. Current licensing requirements for CPR training do not require that caregivers successfully complete a demonstration skills test to be certified. In some local jurisdictions, the licensing staff approves video or online CPR training, however, these trainings do not provide hands-on practice or demonstration of resuscitation skills. In 11 of the cases reviewed by the Child Mortality Review Panel, providers failed to call 9-1-1 or did not initiate CPR upon finding the child unresponsive. In some cases, the provider called a neighbor, friend or spouse asking them to respond to an emergency, rather than calling 9-1-1. Whether CPR was initiated prior to the arrival of a first responder is not always documented in the police reports, so it is unknown in how many cases cardio pulmonary resuscitation or contacting 9-1-1 was delayed.

The Panel recommends that licensed child care providers complete classroom pediatric CPR training provided by the American Red Cross or American Heart Association that includes a

demonstration of skills testing for certification. Video or online training should not be an acceptable alternative for classroom training. The Red Cross and American Heart Association offer classes throughout the state for those who are required to have CPR training for their employment. To maintain CPR certification, the training must be repeated every two years.

The National Association of Child Care Resource and Referral Agencies stated, “The number of required annual training hours for caregivers in most states is very low and insufficient to ensure that providers have the knowledge and skills needed to care for young children.” The National Resource Center for Health and Safety in Child Care and Early Education recommends that applicants for a family child care license complete 40 hours of pre-service training and 24 hours of annual training to maintain their license. Minnesota currently requires family child care providers to have initial training that consists of two hours of child growth and development, first aid, CPR, Prevention of Shaken Baby Syndrome and Risk Reduction for Sudden Infant Death Syndrome. The license holder and each caregiver must complete eight hours of annual training. Subjects for annual training must be selected from areas specified in Minnesota Statute, section 245A.50, subdivision.7, including: child growth and development; learning environment and curriculum; assessment and planning for individual needs; interactions with children; families and communities; health, safety and nutrition; and program planning and evaluation.

For both pre-service and annual training, providers must document that they obtained the training, but currently there is no way of determining, through licensing processes or procedures, whether a provider has successfully mastered and is able to comprehend the information provided in the training. DHS will explore developing a written competency exam for providers to demonstrate their knowledge of training content.

The Child Mortality Review Panel recommends that licensed family child care providers complete 40 hours of DHS-approved pre-service training including an eight-hour course, “Supervising for Safety” as well as 24 hours of annual training. It is also recommended that licensing workers complete the eight-hour “Supervising for Safety” course.

Table 2: Minnesota’s current initial/annual training requirements for licensed family and group family child care providers

Type of training	Number of training hours required	Frequency that training must be repeated	Video training meets requirement	Trainer
Child growth and development	Two hours during first year of licensure	Not specified	Not specified	Not specified
First aid	May be less than eight hours	Not specified	Yes – Approved by county licensing agency	Individual qualified to provide training
Cardio Pulmonary Resuscitation	Not specified	Once every three years	Yes – Approved by county licensing agency	Individual approved to provide CPR instruction
Reduce risk of Sudden Infant Death	At least 30 minutes	Once every five years	No	Approved by county licensing agency
Prevention of Shaken Baby Syndrome	At least 30 minutes	Once every five years	No	Approved by county licensing agency
Video on prevention of Shaken Baby Syndrome	Not specified	Annually	Yes – Approved by Commissioner of Health	Not specified
Child passenger restraint system (only required if provider transports or will transport children)	At least one hour	Once every five years	No	Certified and approved by Dept. of Public Safety
Annual Training	8 hours	Annually	Not specified	Approved by county licensing agency

Additional Supports for Training and Quality Improvement

To help licensed family child care providers meet licensing requirements for training, health and safety practices and offer high quality care, the Department of Human Services provides additional supports with federal and state funding. In addition to considering recommendations

that may change licensing requirements, the Child Mortality Review Panel explored aligned strategies that would increase the scope or effectiveness of these supports in order to ensure that providers have needed information and adequate resources with which to implement best practices that can reduce infant deaths. These supports include:

- Grants and financial supports for providers and Parent Aware, Minnesota's Quality Rating & Improvement System (QRIS), a voluntary program that recognizes child care provider quality and provides assistance in improving quality. Parent Aware is being phased in across Minnesota and will be available statewide in 2015.
- Training, coaching, consultation and other workforce supports for providers to increase their knowledge and skills in child development, instructional practices and ways to meet the needs of individual children. Currently, approved training is available statewide through the Child Care Resource & Referral Network. This training meets standards for best practices in adult learning and is offered by trainers with levels of education and experience appropriate for the subject matter being taught. Requiring child care providers to take training approved through the Minnesota Center for Professional Development could impact the quality of the training providers take to meet training hours for licensure.

Public information

Consumer information resources include support in understanding and finding quality child care through Minnesota's Child Care Resource & Referral Network through on-line and phone referral services. The Parent Aware rating tool helps parents identify providers who participate in a voluntary rating system demonstrating levels of quality above those required by licensing.

The Minnesota Department of Human Services provides Licensing Lookup information on the agency's website to enable parents to learn whether a licensed child care home has an active license or whether the provider's license is conditional, suspended or revoked. Since licensing complaints are addressed at the local level, correction orders issued by the county are not posted on the web-site. If parents call the local agency to inquire about licensing complaints, they will be provided public information. It is possible that parents will make child care decisions without knowing about the history of licensing complaints. The Panel recommends that the Licensing Lookup website be enhanced to include information provided by local agencies about complaints and correction orders.

Capacity and adult to child ratio

The license capacity means the total number of children, ten years of age or younger permitted at any one time in the residence. The license capacity includes all children of the caregiver when the children are present in the residence. Within the license capacity, Minnesota Rules 9502.0365 specifies the age distribution of the children under a provider's care, detailed in Table 3.

Minnesota's child care license capacity and adult to child ratios are higher than the capacity and ratio recommended by the National Resource Center for Health and Safety in Child Care and Early Education (known as NRC-kids). They recommend that when infants are in the care of a small or large group family child care home the ratio of two infants to one adult, detailed in Tables 4 and 5.[NRC-kids, Caring for Our Children, third edition]. The NRC-kids recommendations further clarify that when there are mixed age groups including infants and toddlers, the adult ratio and group size for infants and toddlers should be maintained. In large family child care homes with two or more caregivers/teachers caring for no more than 12 children, no more than three children younger than 2 years old should be in care.

The rationale for the NRC-kids adult/child ratio recommendation is extensive, but includes in part:

- Low ratios between adults and non-ambulatory children are essential for fire safety.
- Studies have found that children (particularly infants and toddlers) in groups that comply with the recommended ratio receive more sensitive and appropriate caregiving and score higher on developmental assessments, particularly vocabulary.
- Low child/adult ratios are most critical for infants and young toddlers. Infant development and caregiving quality improves when group sizes and child/adult ratios are smaller. Improved verbal interactions are correlated with lower ratios.
- Children's physical safety and sanitation routines require an adult that is not stressed by excessive demands. Child/adult ratios should be sufficiently low to keep stress below levels that might result in anger with children.
- Ratios are required to be maintained for children 30 months and younger during nap times. Close proximity to these young children enables more rapid response in an emergency.
- Children benefit from social interactions with their peers, however, larger groups are generally associated with less positive interactions and developmental outcomes.
- The NRC-kids ratio recommendations assume that the providers and staff are well-trained.

Table 3: Minnesota’s Adult/child ratios; age distribution restrictions

Classification	Licensed capacity	Adult/child ratio	Total under school age	Total infants and toddlers
Family Daycare				
Class A	10	1 adult/10 children	6	Of the total children under school age, a combined total of no more than 3 shall be infants and toddlers. Of this total, no more than 2 shall be infants.
Specialized infant and toddler family day care				
Class B1	5	1 adult/5 children	3	No more than 3 shall be infants.
Class B2	6	1 adult/6 children	4	No more than 2 shall be infants.
Group Family Day Care				
Class C1	10	1 adult/10 children	8	Of the total children under school age, a combined total of no more than three shall be infants and toddlers. Of this total, no more than two shall be infants.
Class C2	12	1 adult/12 children	10	Of the total children under school age, no more than 2 shall be infants and toddlers. Of this total, no more than 1 shall be an infant.
Class C3	14	2 adults/14 children	10	Of the total children under school age, a combined total of no more than 4 shall be infants and toddlers. Of this total, no more than 3 shall be infants. A helper (age 13 - 17) may be used in place of a second adult caregiver when there is no more than 1 infant or toddler present.
Specialized infant and toddler group family daycare				
Class D	9	2 adults/9 children	7	Of the total children, no more than 4 shall be infants.

The Child Mortality Review Panel is concerned about licensing capacity being a contributing factor in the child deaths in licensed child care. This limits the ability of child care providers to provide appropriate supervision to all children in their care, especially the youngest and most vulnerable. Minnesota’s capacity and adult/child ratio far exceeds the national standards. The Panel recommends that Minnesota adopt the national standards for capacity and ratio to ensure that children are adequately supervised and safe while in licensed child care.

Table 4: NRC-kids ratios for large family child care homes and centers

Age	Maximum child/staff ratio	Maximum group size
Less than 12 months	Two children/one adult	Six
13-23 months	Two children/one adult	Eight
24-35 months	Three children/one adult	12
3-year-olds	Seven children/ one adult	12
4-5-year-olds	Eight children /one adult	12
6-8-year-olds	10 children /one adult	12
9-12-year-olds	12 children /one adult	12

Table 5: NRC-kids ratios for small family child care homes

Age of children in care, including the provider’s own children	Capacity
No children under age 2 in providers care	One–six children over 2 years of age in care
One child under age 2 in care	One–three children over age 2
Two children under age 2 in care	No children over age 2 in care

Oversight

According to Minnesota Statute 245A.16, a county agency may authorize licensing reviews every two years after a license has had at least one annual review. Most of Minnesota’s licensing workers inspect family child care homes prior to licensure, after one year and then once every two years. Inspections by the licensing agency help to ensure that providers are aware of and comply with licensing regulations. The recommendations from the National Association of Child Care Resource and Referral Agencies stated in their recommendations, “Weak oversight undermines strong standards since compliance is not effectively monitored.” It recommends that family child care homes be inspected at least quarterly. The Child Mortality Review Panel recommends annual inspections for family and group family child care homes, falling short of the national best practice recommendation, but doubling the current frequency of inspections.

Safe infant sleep

Most of the deaths in licensed child care involved an infant placed in an unsafe sleep environment or unsafe sleep position. Minnesota Statutes, section 245A.1435, requires that licensed child care providers place infants to sleep on their back. The only exception to this is if the provider has in their possession a form approved by DHS, signed by the parent, authorizing

the provider to place the infant in an alternative sleep position. The parental directive is intended to be an exceptional situation due to special health needs of the infant. The Child Mortality Review Panel recommends that Minnesota Statutes, section 245A.1435, be amended to require a physician sign a form approved by DHS and indicate the length of time that an alternative sleep position will be required to address an infant's diagnosed medical condition.

The statute also requires that the license holder must place the infant for sleep on a firm mattress with a tight fitting sheet that cannot become dislodged. Soft items such as pillows, blankets, quilts, comforters, sheepskin, stuffed toys and other soft items must not be in the crib with the infant. This safe sleep requirement applies to infants up to and including 12 months of age. Licensed providers are required to have training, approved by DHS, on reducing the risk of Sudden Infant Death before they begin caring for children and once every five years thereafter. The Panel recommends that the training to reduce risk of Sudden Infant Death be required to be completed annually by the license holder.

There were 65 infant deaths in licensed child care that occurred while the infant was sleeping. Thirty-six of the infant deaths were found to have occurred in an unsafe sleep environment resulting in sanctions to the provider for violating licensing regulations. Infants may have been placed to sleep on their stomach or side; or placed on an adult bed or other surface not intended for infant sleep, or placed in a crib with soft items. Some infants were placed to sleep in a portable crib that was safely designed with a very firm mattress but when a folded quilt or blanket is placed over the mattress, creating a soft sleep surface and an unsafe sleep environment. Soft bedding can obstruct an infant's airway. Loose blankets, pillows or stuffed toys were often found in the crib with the infant when they were found unresponsive.

Case documentation indicated that some infants were placed to sleep, and left to sleep for two to four hours. Longer hours of sleep would be expected during the night, but during daytime hours, they should have short naps between periods when they are awake, playing and interacting with others. Sometimes providers check on sleeping infants through a partially closed door into a dimly lit room. When providers check on sleeping infants, they should look at a child's sleep position, chest rise, skin color and temperature. Providers should check on infants at frequent intervals. The National Resource Center for Health and Safety in Child Care and Early Education recommends that sleeping infants require close supervision, and should be directly observed by sight and hearing at all times, including when they are sleeping. The lighting in the room must allow caregivers to see each infant's face, to view the color of their skin, and to check on their infant's breathing and placement of a pacifier. The Child Mortality Review Panel recommends that infants sleeping in licensed family child care should be checked frequently, at least every 15 to 30 minutes.

National studies of Sudden Unexpected Infant Death identified trends have been noted in Minnesota's child care deaths. Nationally, there is a higher incidence of infant deaths during their first week in child care. There is also a pattern that some infants died suddenly while they exhibited symptoms of an upper respiratory infection, although the autopsy findings did not indicate an infection caused the death. The reason for these patterns is unknown, but closer supervision of infants during their first weeks in a new child care home and when they have an upper respiratory infection is necessary.

Local agency response

The local agency response to licensing violations varied. Investigations following child deaths in licensed child care sometimes reveal licensing violations that impact children's safety, resulting in the suspension and revocation of the provider's license. In some cases, a licensing violation was not investigated because the death was diagnosed as Sudden Unexpected Infant Death and not perceived by the licensing worker as preventable. The licensing agency needs to gather law enforcement investigative reports and consider the infant's sleep environment when conducting investigation of a death in a licensed facility. In some jurisdictions, a death in a licensed facility involving an infant placed in an unsafe sleep environment results in a child protection facility investigation and determination of neglect. The Child Mortality Review Panel recommends that there be consistent response by local agencies to investigate the provider's compliance with licensing regulations following every child death and to cross report to child protection when there are findings that the provider was negligent of the child's health and safety. The child protection screening guidelines should be revised to require a child protection facility investigation when a provider violated mandated safe infant sleep regulations. Local agency licensing workers and child protection workers need to be trained in safe infant sleep to prevent deaths and to better assess licensing violations or child protection facility reports of safe sleep violations.

DHS response

When a provider's child care license has been suspended or revoked due to violation of safe infant sleep regulations, the sanction is often appealed by the provider. The appeal process has varied results with some providers having their license reinstated, some reach a settlement with DHS, and for others the agency decision to suspend or revoke the license is affirmed. Sanctions for violations of the safe infant sleep regulations need to be consistent and strong to be effective at increasing compliance. The Panel recommends that DHS administrative law judges be advised of the American Academy of Pediatrics recommendations for safe infant sleep to better understand the rationale for the sanctions. The Panel also recommends that any violation of safe infant sleep regulations require revocation of a provider's child care license.

Further study

The Minnesota Department of Health received funding from the Centers for Disease Control and Prevention to study sudden unexpected infant deaths. Minnesota is one of seven states involved in the study to learn more about factors that contribute to these tragic deaths. The study involves infant deaths that occur in all settings with any cause of death diagnosis. In addition, MDHS requested the Minnesota Department of Health to conduct an epidemiological study of infant deaths that occurred in licensed child care settings. Of particular concern are the high number of deaths in family child care settings and the comparatively low number in licensed child care centers. The Department of Health has interest in conducting this research, if resources to fund the study are available.

Conclusion

Following a child's death, the lives of their family members are forever changed. As a social services system, we must all do whatever is necessary to protect the lives of these vulnerable children.

Recommendations

Statutory and administrative rule changes

- Make Minnesota licensing statutes consistent with the most recent recommendations of the American Academy of Pediatrics for safe infant sleep.
- Require a physician's authorization to permit a licensed child care provider to place an infant to sleep in any position other than on their back in a crib. The physician authorization form will be provided by DHS.
- Require all family child care providers hold liability insurance as a requirement for licensure.
- Require local social service agencies to conduct annual inspections for all classifications of family child care homes.
- Require that a child care provider's license be revoked when an infant in the care of a licensed child care facility is in an unsafe sleep position or unsafe sleep environment.
- Clarify that neglect includes an infant placed in an unsafe sleep environment while in the care of a licensed child care or foster care facility.
- Require annual training on reducing risks of Sudden Unexpected Infant Death and prevention of Shaken Baby Syndrome for licensed child care providers. Include in the course curriculum the risk of death to an infant and the consequences to the provider's license.
- Require licensed child care providers to complete Red Cross or American Heart Association classroom pediatric CPR and first aid training, pass a written exam and skills demonstration test for CPR certification prior to licensure. Online or video training courses cannot be substituted for the classroom course and skills demonstration test. Classroom and skills demonstration test must be repeated every two years.

- Modify license capacity and adult to child ratios to be consistent with the best practice standards established by the National Resource Center for Health and Safety in Child Care and Early Education’s “Caring for Our Children,” third edition.
- Require applicants for a family child care license to complete 40 hours of DHS-approved pre-service training; require 24 hours of DHS approved annual training to be consistent with national child care standards.
- Require applicants for a family child care license hold a high school diploma, GED or equivalent. A waiver could be provided for immigrant applicants for a child care license if they earned a high school diploma, GED or equivalent before moving to the United States, but are unable to provide verification of their education.
- Increase the minimum age of child care “helpers” to 16 years old.
- Require applicants for a child care license to complete all required training before the initial license is granted.
- Replace in statute, the term, “Sudden Infant Death (SIDS)” with Sudden Unexpected Infant Death; replace Shaken Baby Syndrome with the more accurate diagnostic term Abusive Head Trauma to be consistent with current diagnostic terms.
- Expand sanctions to providers following a serious licensing violation.
- Require that providers must show competence to provide safe child care through a written exam to obtain child care licensure.
- Require family child care providers to observe sleeping infants at frequent intervals
 - Require operating an audio/visual monitoring device used when infants are sleeping, in addition to in-person checks of infants every 15 to 30 minutes.
 - Require providers to check on sleeping infants by looking for chest rise, skin color, skin temperature, along with recognition of crib safety issues.
 - Require more intense supervision of infants during the first four weeks in a new child care home, and when an infant has an upper respiratory infection.

Increase public awareness

- Add correction orders made by county social service agencies to family child care providers available on the DHS website on the Licensing Lookup screen.
- Provide information to parents on sleep safety issues and encourage them to observe their child’s sleeping environment at a child care facility, and reinforce safe sleep position and environment for their infant.

Improve quality and consistency of oversight

- Improve local practice to increase consistency in response to a licensing violation and child protection investigation in a licensed child care facility.
- Revise the child protection screening guidelines to clarify that a child maltreatment facility investigation is required when an infant is placed in an unsafe sleep environment or unsafe sleep position while in the care of a licensed child care provider.
- Review correction orders and negative actions issued by local social service agencies and DHS for consistency applied to similar violations.
- Direct licensing workers to complete the “Supervising for Safety” and “Reduce Risk of Sudden Infant Death” courses that are required for child care providers, to increase consistency among counties following a violation of safe sleep requirements or other safety violations.

- Consider developing a written competency exam for providers to demonstrate their knowledge of training content.

Training

- Review materials used for training licensed providers on safe infant sleep and supervision during naps, and strengthen the training to be consistent with current American Academy of Pediatrics recommendations, include information on best practices on soothing infants to help them fall asleep.
- Update and revise training curriculum on safe infant sleep for licensing workers.
- Update the Minnesota Child Welfare Training System's child protection facility investigation course to include the American Academy of Pediatrics recommendations on safe infant sleep.
- Require all providers to complete an eight-hour "Supervising for Safety" training.
- Require child care mentors, coaches, consultants and trainers to have safe infant sleep training.
- Provide communication to providers and child care organizations, including key messages about the reasons for the statutory changes involving infant safety.

Further research needed

- Request the Minnesota Department of Health commissioner to conduct an epidemiological study of infant deaths in licensed child care facilities to examine the etiology of the infant deaths and the cause for the higher incidence of deaths in family child homes than in child care centers.

Bibliography

American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care and Early Education. 2011. *Caring for our children: National health and safety performance standards; Guidelines for early care and education programs*. Third Edition. Elk Grove Village, IL: American Academy of Pediatrics; Washington, D.C.: American Public Health Association.

Also available at: <http://nrckids.org>.

Chase, R., Arnold, J., and Schauben, L and Wilder Research, (2006). *Family, Friends and Neighbors Caring for Children Through the Minnesota Child Care Assistance Program: A Survey of Caregivers and Parents*. (DHS-4517).

Also available at: <http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4517-ENG>

Chase, R., Valorose, R., and Wilder Research, (2012). *Child care workforce in Minnesota: 2011 statewide study of demographics, training and professional development*. (DHS-5115A).

Also available at: <https://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-5115A-ENG>

Chase, R., Valorose, J. and Wilder Research, (2010). *Child Care Use in Minnesota: Report of the 2009 Statewide Household Child Care Survey*. (DHS 6278-ENG).

Also available at: <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6278-ENG>

Task Force on Sudden Infant Death Syndrome, SIDS and Other Sleep Related Infant Deaths: Expansion of Recommendations for a Safe Infant Sleeping Environment, *Pediatrics*, Volume 128, Number 5, November 2011.

Also available at: <http://pediatrics.aappublications.org.org/content/early/2011/10/12/peds.2011-2284>

National Association for Child Care Resource and Referral Agencies - Child Care Aware of America website. <http://www.naccrra.org/>

Child Mortality Review Panel Members

Ann Ahlstrom, J.D.*

Children's Justice Initiative
Minnesota State Court Administration

Nan Beman, M.S.W.

Social Service Information System
Minnesota Department of Human Services

Linda Billman, M.S.W.*

Social Services Consultant
Minnesota Department of Human Services

Christeen Borsheim, M.P.A.*

Child Safety and Permanency Division
Minnesota Department of Human Services

Ruth Clinard*

Child Mortality Review Consultant
Minnesota Department of Human Services

Kathy Eilers, J.D.

Assistant County Attorney
Ramsey County Human Services

Leila Farah

Consultant
Minnesota Department of Human Services

Matthew Frank, J.D.*

Public Protection/Criminal Appeals Manager
Minnesota Attorney General's Office

Stephanie Graves

Public Health Nurse
Minneapolis Department of Health

Butch Huston, M.D.*

Forensic Pathologist
Ramsey County Medical Examiner's Office

Jennifer Alexander, L.I.S.W.

Student Maltreatment Program Supervisor
Minnesota Department of Education

Terry Besaw, M.S.W.

Child Protection Consultant
Minnesota Department of Human Services

Joanne Boogaard, M.P.H.*

Planning, Policy and Quality Assurance
Hennepin County Human Services and Public
Health Department

Mary Jo Chippendale, M.S., P.H.N.*

Family and Women's Health Supervisor
Minnesota Department of Health

Brian Coyle, Sr. Commander*

Homicide/Robbery/Cold Case Unit
Saint Paul Police Department

Drew Evans, J.D.*

Senior Special Agent
Minnesota Bureau of Criminal Apprehension

Kathleen Fernbach P.H.N.*

Minnesota Sudden Infant Death Center
Children's Hospitals and Clinics of Minnesota

Victor Froloff, M.D.

Forensic Pathologist
Ramsey County Medical Examiner's Office

Mark Hudson, M.D., F.A.A.P.*

Child Abuse Pediatrician
Children's Hospitals and Clinics of Minnesota

Mary Kelsey*

Assistant Licensing Supervisor
Minnesota Department of Human Services

Mark Kinde, M.P.H.*
Injury and Violence Prevention Unit Leader
Minnesota Department of Health

Lara Lawani, M.D.*
Injury and Violence Prevention Unit
Minnesota Department of Health

Carolyn Levitt, M.D., F.A.A.P.
Midwest Children's Resource Center
Children's Hospitals and Clinics of MN

Joanne Mooney, M.A.
Children's Trust Fund Consultant
Minnesota Department of Human Services

Amelia Ortega
Children's Mental Health Parent Liaison
Minnesota Department of Human Services

Don Pelton
Child Protection Supervisor
Washington County Community Services

Karen Pitts*
Child Development Services Supervisor
Minnesota Department of Human Services

Janet Spatafore, P.H.N., M.S.N.
Public Health Nurse
Wright County Health Department

Erin Sullivan Sutton, J.D.*
Children and Family Services Administration
Minnesota Department of Human Services

Esther Wattenberg, M.A.
Center for Urban and Regional Affairs
University of Minnesota

Jo Zillhardt, R.N.-B.C., P.H.N.
Office of Ombudsman for Persons with
Developmental Disabilities and Mental Illness

Ad hoc members to the Child Care Issues Subcommittee include:

Jerry Kerber, J.D.*
Inspector General
Minnesota Department of Human Services

Deb Swenson-Klatt*
Child Development Services Manager
Minnesota Department of Human Services

Jamie Sorenson*
Training and Quality Assurance Manager
Minnesota Department of Human Services

Laura Zrust, J.D.*
Licensing Division Director
Minnesota Department of Human Services

*Child Care Issues Subcommittee members



Minnesota Department of **Human Services**