



**OFFICE OF FINANCIAL MANAGEMENT**

**LOSS PREVENTION REVIEW TEAM**

REPORT TO THE DIRECTOR OF THE OFFICE OF FINANCIAL MANAGEMENT

Department of Social and Health Services, Economic Services Administration  
Division of Child Care and Early Learning  
Incident of January 2004

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# SECTION I – EXECUTIVE SUMMARY

## **CONTEXT**

An incident involving serious injury to a person at a family home child care facility occurred on January 12, 2004. The injury was related to the licensing and enforcement activity of the Department of Social and Health Services (DSHS), Division of Child Care and Early Learning (DCCEL).<sup>1</sup> In accordance with RCW 43.41.370, Victor Moore, Director of the Office of Financial Management (OFM) is authorized to appoint a loss prevention review team (LPRT) when an incident resulting in death, serious injury to a person or other substantial loss is alleged or suspected to be caused at least in part by a state agency. On April 12, 2005, Mr. Moore determined that this reported incident should be reviewed by a LPRT.

## **INCIDENT SUMMARY**

On January 12, 2004, a family home child care provider severely injured a 23-month-old toddler. The child's family brought a lawsuit that included claims against DCCEL and DSHS. The state settled its portion of the matter for \$4.5 million. The propriety of the care provider's license at the time of the incident gives rise to this study.

## **REVIEW PROCESS**

The LPRT's task was to review the incident, evaluate the causes, and make recommendations regarding child care licensing and enforcement in an attempt to prevent or mitigate future losses of this type.

The LPRT held its first meeting on June 19, 2005. The LPRT coordinator explained the process and assisted the team in developing a review plan. During the summer and fall of 2005, the LPRT members conducted a series of interviews with DSHS staff and other national experts regarding child care licensing and enforcement procedures.

In performing this review, DSHS-DCCEL staff helped the team by providing data and information, identifying the people to interview, and observing the interviews. The investigation concluded on October 28, 2005. After the report was prepared in final draft, DCCEL was given the opportunity to comment.<sup>2</sup> This report incorporates their substantive comments.

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<sup>1</sup> DCCEL is now part of the recently created Department of Early Learning (DEL). DEL began operations on July 1, 2006.

<sup>2</sup> Part of DCCEL comments included the statement, "During the past two years, DCCEL has taken steps to strengthen its oversight of licensed family child care homes, and now conducts a comprehensive licensing performance review process and ongoing reporting of completed monitoring visits... [The agency seeks] to ensure unannounced monitoring visits happen... every 18 months for family home [care facilities]."

## **FINDINGS**

Danette Zaring operated her family home child care facility in Spokane for nearly 12 years. During that time, licensors identified over 20 standards violations that resulted in corrective actions that included placing Zaring on probation. Some of the violations were based on findings that Zaring operated the facility while caring for too many toddlers.

Regulations limited Zaring to a population of two children that were under two years of age. The capacity limit of two infants is based upon infant safety research. One risk of violence to infants from their caregivers derives from a caregiver's possible negative emotional response to infant crying. Thus, infants are at greater risk when their providers try to take care of too many children. In this incident, Zaring was operating over her licensed capacity and after the toddler had been crying and fussy all day, Zaring shook and then threw the child to the floor.

Before the incident, there were standards violations that could have resulted in Zaring's license being revoked. However, Zaring remained in business. There are several possible reasons the enforcement system did not function properly.

Agency personnel believe that excessive caseloads precluded sufficient monitoring visits to the Zaring Day Care, and that this was a contributing factor for the incident. In addition, Spokane-area licensors said that they felt they lacked sufficient agency support for their enforcement actions. This lack of support may have compromised their willingness to attempt to revoke Zaring's license.

Licensors morale was affected by a belief that in their area, administrative law judges (ALJs) had a bias that favored family home child care providers in legal challenges of revocation decisions. Morale may also have been affected by the agency practice of having a single employee – the licensor – conduct two conflicting functions: monitoring and mentoring. Monitoring involves the investigation and enforcement of existing rules, regulations, and laws; the process could result in a license revocation. Mentoring involves helping family home child care facilities to improve their services and to provide better and safer care to children. These two functions are difficult to reconcile in the context of a license revocation.

Other DSHS agencies, such as the Adult and Disability Services Administration (ADSA), utilize other methods of licensing and enforcement of care facilities that appear to have better results. Licensors mentor providers, and make referrals to enforcement personnel when they observe a problem. Licensors do not develop the investigation, and do not impose sanctions. All enforcement actions are centralized, and revocations are determined by staff at agency headquarters. This practice promotes consistency of enforcement of pertinent laws and regulations. The newly established DEL should consider adopting ADSA practices.

## **RECOMMENDATIONS**

The review team believes their work identified root causes of the incident that, if addressed, will prevent or will lessen the likelihood that similar events will occur in the future. With the transfer of regulatory authority from DSHS to DEL, there is an excellent opportunity to address the root causes identified, develop performance measures associated with the changes made to determine their utility, and hopefully achieve different outcomes. The team recommendations are in four interconnected service areas: (1) licensing; (2) community outreach; (3) training initiatives; and (4) enforcement.

### **Licensing:**

- Separate the licensor and enforcement functions.
- Implement an investigation response tracking system.
- Create additional internal audit procedures.
- Update the caseload tracking system.
- Improve provider tracking systems.
- Require annual license renewal.
- Create an automated renewal notification system.
- Institute team review of license renewal applications.
- Centralize the license renewal application process.

### **Community Outreach:**

- Eliminate the current provider complaint process.
- Improve parent access to provider information.
- Increase the amount of provider training.

### **Training Initiatives:**

- Licensor documentation supporting enforcement.
- Investigator documentation supporting licensing.
- Provide regular training to ALJs.

### **Enforcement:**

- Require enforcement staff to work in teams.
- Perform annual inspections.
- Create weighted compliance standards.
- Emphasize enforcement of capacity rules.

## SECTION II – REVIEW PROCESS

### TEAM MEMBERS

In accordance with RCW 43.41.370, OFM Director Victor Moore is authorized to appoint LPRTs when he decides that an incident involving an agency merits review. On April 12, 2005, Mr. Moore appointed the following people to review the family home child care licensing system and the Zaring incident:

- Susan J. Spieker, Professor of Family and Child Nursing, University of Washington School of Nursing;
- Robin Boehler, Board Member, Washington State Childcare Referral Network; and
- Deborah S. Robins, Regional Child and Youth Operations Manager, United States Navy, Region Northwest.

### ACKNOWLEDGEMENTS

The LPRT acknowledges the useful and effective assistance provided by Laura Dallison, Licensing Quality Assurance and Training, DCCEL, in coordinating interviews and obtaining documents, data and information for the team during the course of the review.

### REVIEW PROCEDURE

The LPRT first met on June 19, 2005. The initial discussion addressed confidentiality issues, the review process, development of the review plan, and the roles of the team members and LPRT coordinator.

The LPRT coordinator met with DSHS personnel to discuss the LPRT process. The team then met with DSHS staff to conduct investigative interviews on August 11-12, 2005. Subsequent investigative interviews were conducted by telephone on August 18, September 16, and October 28, 2005.

The following people were interviewed:

<b>Name</b>	<b>Title/Agency</b>	<b>Interview Date</b>
Pat Dickason	Program Manager, Licensing Policy, DSHS	August 11, 2005
Lee Williams	Former Regional Manager, Child Care Licensing, DSHS	August 11, 2005
Sue Gamache	Foster Care Licensing, DSHS	August 11, 2005
Shirley Huguenin	Child Care Licensing, DSHS	August 11, 2005

<b>Name</b>	<b>Title/Agency</b>	<b>Interview Date</b>
Claudia Jurgensen	Social Worker 2, DSHS	August 12, 2005
Shannon Selland	CPS Social Worker, DSHS	August 12, 2005
Tim Nelson	OCCP Regional Manager, DSHS	August 12, 2005
Connie Morlin (Bacon)	Area Administrator, DSHS	August 12, 2005
Denise Gaither	Aging and Disability Services, DSHS	August 18, 2005
Mary Oakden	Policy Program Manager, DSHS	August 18, 2005
Laura Dallison	DCCEL Licensing Policy, DSHS	August 18, 2005
Karen Tvedt	Executive Director, Early Learning Council, Washington Learns	September 16, 2005
Rachael Langen	Director, Division of Early Child Learning, DSHS	October 28, 2005
Lynnette McCarty	President, National Association of Child Care Professionals	October 28, 2005

On December 13, 2005 the LPRT began to formulate recommendations. The LPRT coordinator continued to draft the final report, but moved to a different position outside of OFM in June 2006. A new coordinator was appointed on December 1, 2006 and finalized the draft on January 18, 2007.

The LPRT coordinator sent a draft of the report to members in January 2007 for their review and comment. The report was completed on March 23, 2007.

### **SECTION III – FINDINGS**

This section of the report will address the cause of loss, the resulting loss to the state of Washington, the pertinent policies underlying the licensing of a family home child care facility, and issues arising from the enforcement of regulations pertinent to this incident.

#### **CAUSE OF LOSS**

At the time of her injury, the child (H.R.) was just under two years old. Both parents worked full-time, so they sent H.R. to a family home child care operated by Danette Zaring, a childhood friend of the father. Zaring was licensed as a family home child care provider in 1991. Zaring's mother had also operated a family home child care facility, but her license was revoked in 1991.

On January 12, 2004, H.R. was fussy and was not feeling well at the time she arrived at the Zaring home. When her mother picked her up that evening, H.R. seemed to be in the same fussy condition. Zaring said that H.R. had fallen off a bed and bumped her head. H.R. had a small red mark by her left eye.

Early the next morning, H.R. began to have a seizure and had trouble breathing. She was rushed to a hospital, where doctors discovered that she had a subdural hematoma (a blood clot inside her skull). While surgery saved the child's life, she had permanent brain damage. Physical and speech therapy are ongoing.

A toddler bumping into an object or falling while playing would not typically sustain a blood clot of the size, type and location that the doctors found when treating H.R. Based on these facts, they called the police to investigate the injury.

Initially, the police focused on the family as the possible source of the abuse. The focus shifted to Zaring because her version of events changed with each interview by investigators. On January 14, 2004, Zaring confessed to throwing H.R. onto the floor, which knocked the child unconscious. H.R. appeared to stop breathing for between one and five minutes. Zaring blew on H.R.'s face to get her to breathe, and then to wake up. After H.R. awoke, Zaring did not report the incident or seek medical help because "the child seemed fine." Questions subsequently arose regarding the propriety of Zaring's license to operate a family home child care facility.

On September 28, 2005, Zaring pled guilty to second-degree assault of a child, and first-degree criminal mistreatment. She was sentenced to five years in prison.

## **RESULTING LOSS**

The family sued DSHS and Zaring. DSHS settled the matter for \$4.5 million.

### ***Policies and Procedures: Family Home Child Care***

#### **A. Introduction**

Today, parents use a variety of child care settings. Children are cared for (1) in their family home by their parents, by family, friends or neighbors, or by providers; (2) in unlicensed child care settings outside the home; (3) in family child care homes; and (4) in child care centers operated by both for-profit and non-profit organizations. With regard to family child care homes, the state has the legal responsibility to license and enforce regulations and laws setting minimum standards for the operation of such facilities.

Below, we provide a brief overview of the statutory, regulatory, and agency policies and procedures applicable to family home child care facilities.

## **B. Washington Law Regulating Family Home Child Care**

Washington State has one of the longest state child care facility licensing histories in the nation. Child care centers have been licensed since the 1930s; family home child care licensing began in the 1960s.

Researchers note that Washington's laws regulating child care facilities are more comprehensive than in most states. Statutes set forth the basic standard for licensure and operation; department regulations interpret the statutes. Department manuals are designed to provide guidance for licensing and enforcement staff. The laws, regulations, and practice manuals embody the minimum standards that department personnel are to apply to child care providers. Proper administration of licensing and enforcement laws, regulations and rules promotes the safety of children in Washington child care facilities.<sup>3</sup>

### ***Brief History of Statutory Authority***

In 1987, the legislature gave DSHS primary responsibility for providing training to parents and licensed child care providers in order to prevent child abuse and neglect.<sup>4</sup> At that time, licensing of child care providers was administered by the Children's Administration<sup>5</sup> through Child Protective Services (CPS).<sup>6</sup> Investigations within CPS inquire whether an allegation of abuse and/or neglect is founded or unfounded. Enforcement of licensing regulations followed this model, and a license would be revoked only upon a finding that an abuse or neglect allegation was founded.<sup>7</sup>

In 1989, the legislature provided a "Statement of policy for the provision of child care services" that informed DSHS' work related to child care facility licensure. The statement accompanied Governor Booth Gardner's task force report on child care in relation to welfare reform. The law (RCW 74.13.085) declares that it is statewide policy to:

(1) Recognize the family as the most important social and economic unit of society... there has been a dramatic increase in participation of women in the workforce, which has made the availability of quality, affordable child care a critical concern for the state and its citizens. There are not enough child care services and facilities to meet the needs of working parents, the costs of care are often beyond the resources of

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<sup>3</sup> The laws and standards differentiate between operating a child care center and a family child care home.

<sup>4</sup> RCW 74.15.200.

<sup>5</sup> The Children's Administration is a "cluster of programs within DSHS that is responsible for the provision of child protective, child welfare, foster care licensing, group care licensing, and other services to children and their families." WAC 388-15-005.

<sup>6</sup> Child Protective Services is the section of the Children's Administration that responds to allegations of child abuse and neglect. WAC 388-15-005.

<sup>7</sup> Based on the LPRT investigation, an allegation of abuse or neglect that was not founded by CPS will be given careful consideration when deciding whether to revoke a license.

working parents, and child care facilities are not located conveniently to work places and neighborhoods. Parents are encouraged to participate fully in the effort to improve the quality of child care services.

(2) Promote a variety of culturally and developmentally appropriate child care settings and services of the highest possible quality in accordance with the basic principle of continuity of care. These settings shall include, but not be limited to, family child care homes, mini-centers, centers and schools.

(3) Promote the growth, development and safety of children by working with community groups including providers and parents to establish standards for quality service, training of child care providers, fair and equitable monitoring, and salary levels commensurate with provider responsibilities and support services.

(4) Promote equal access to quality, affordable, socio-economically integrated child care for all children and families.

(5) Facilitate broad community and private sector involvement in the provision of quality child care services to foster economic development and assist industry. RCW 74.13.085

Also in 1989, the legislature created the Office of Child Development (OCD), which DSHS operated within the Children's Administration. The OCD addressed child care policy exclusively, while CPS retained child care licensing and enforcement functions. In 1993, the legislature created the Office of Child Care Policy (OCCP), which was the state's counterpart to the child care resource and referral network operated by non-profit organizations for parents and businesses. CPS transferred its child care licensing and enforcement responsibilities to OCCP that year. OCCP retained the CPS method of inquiry regarding licensing and enforcement (*i.e.*, child care facilities were either licensed and operated, or closed down if allegations of unsafe conditions were determined to be valid).

In 1995, the legislature provided DSHS with an expanded arsenal of enforcement tools, which are still in effect today. These tools include assessment of civil penalties, or suspension, modification, or non-renewal of the child care license.<sup>8</sup>

In 1997, DSHS created the Division of Licensing Resources (DLR) in the Children's Administration to administer both the foster and child care licensing functions.

In 2001, DSHS moved the family home child care licensing and enforcement functions to DCCCEL.

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<sup>8</sup> RCW 74.15.130.

In July 2006, DCCEL was transferred to the Department of Early Learning (DEL).<sup>9</sup> As is discussed below, the regulatory framework for license enforcement in DEL-DCCEL continues to be applied using the original models first developed when licensing was a function of CPS.

### ***Regulatory Framework***

When the Zaring family child care facility first began operation, rules and regulations governing family home child care were collected in WAC 388-71.<sup>10</sup> Highlights of pertinent WAC provisions regarding licensing qualifications and licensing compliance are collected in Appendix A. The regulations implement the policies and statutes regarding family home child care providers, and are designed to promote the safety, health and well-being of children in the care of such providers.

### ***Agency Policies and Procedures***

Agency manuals provide guidance to those personnel who are charged with licensing only qualified persons who seek to provide family home child care, and who enforce the laws and regulations governing such facilities.<sup>11</sup> Originally, when the licensing function was performed by staff in the Division of Child and Family Services (DCFS), there were three core areas of focus for the licensing and enforcement functions pertinent to this study. One was to license child care homes and centers to minimum safety standards. The second was to enforce the operation of the facilities to such standards. The third was to assist child care providers to improve their methods of caring for children. Importantly, the original manual for DCFS enforcement recognized the balance that staff must strike when analyzing providers: “The basic purpose of licensing is to protect and promote the welfare of persons in the care of licensed facilities. At the same time, the rights of licensees must be respected.”<sup>12</sup> Where there is a direct conflict between these rights, the agency will opt for the best interests of the child.

Over time, additional policy initiatives were included in enforcement manuals that had an impact on licensing decisions and enforcement, including:

- The responsibility to increase the supply of high-quality child care by facilitating recruitment and training efforts.
- The introduction of several “customer service” principles, intended to guide licensure interactions with child care providers during investigations and inspections, that included (a) providing clear expectations for provider

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<sup>9</sup> RCW 43.215.300.

<sup>10</sup> In 2000, the rules for licensing family home child care facilities were recodified as WAC 388-155, and in 2004, were again recodified as WAC 388-296. They are now located in WAC 170-296.

<sup>11</sup> Excerpts of these manuals are discussed in Appendix B. A copy of DEL’s current licensure training manual is included in Appendix C.

<sup>12</sup> DCFS Manual, Chapter 6, at 10 (1984).

conduct, (b) “compassionate listening” to providers, (c) responsiveness to provider communications, (d) fairness (*i.e.* consistency) in the enforcement process, and (e) respectful communications with providers.<sup>13</sup>

In addition, the DCCEL manual introduced the concept that any “person who applies for a child care license and meets the minimum licensing requirements of the program is entitled to a license.”<sup>14</sup> The manuals describe the enforcement balance that must be considered between protecting and promoting child welfare and preserving the business rights of child care providers.

## **ENFORCEMENT OF FAMILY HOME CHILD CARE REGULATIONS: THE ZARING INCIDENT**

This section addresses the overall license application and enforcement actions regarding Zaring Day Care. It contains a timeline of agency enforcement activity. An overview of the feedback from DSHS personnel regarding what did, and what did not function well in the enforcement process is included. The section concludes with analysis of the enforcement actions.

### ***License Application and License Enforcement Procedures***

Danette Zaring originally applied for a license in 1991. Although some aspects of the application process have changed since 1991, the overall licensing and enforcement process described below accurately states the procedures that have governed family home day care facilities for the past 15 years.

A family home child care license application requires an applicant to self-assess certain skill sets and the applicant’s home environment. After receipt of the application, a licenser is required to visit and tour the proposed child care facility, and interview the care provider.<sup>15</sup> In addition, criminal record background checks are performed on the provider and all resident family members.

The decision to license a facility must be approved by a licenser’s supervisor. A license is valid for three years, with licensing fees due annually. Non-payment of the annual fee should result in a lapse of the license. DSHS (and now DEL) has the right and obligation to oversee and enforce a provider’s performance as a licensed family home child care facility. Regulations require one unannounced licensing visit every 18 months.

If a complaint is made regarding the care provider, licensers are also the assigned investigators. Investigations sometimes include home visits or phone inquiries. If child abuse or neglect (CA/N) is reported to (or identified by) the licenser, a referral is made for a CPS investigation. Thus, CA/N reports result in parallel reviews conducted both by the licenser and CPS. As a result of the investigations, CPS determines whether the

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<sup>13</sup> OCCP Manual, at 2-6 (1997).

<sup>14</sup> DCCEL Manual, at 13 (2001).

<sup>15</sup> In 1991, the licenser was a DSHS employee. Currently, this function is performed by DEL staff.

reports were (1) unfounded, (2) founded, or (3) inconclusive. Licensors separately determine whether the allegations of licensing violations are (1) invalid, (2) valid or (3) inconclusive.<sup>16</sup>

If allegations of abuse or neglect are determined to be “founded” by CPS, licensors often take immediate steps to revoke the family home child care license, or require the abuser to leave the facility during child care hours. If a complaint is validated, or if other standards violations are noted during a site visit, the licensor can use a variety of enforcement tools to bring a provider into compliance.<sup>17</sup> If children are deemed in imminent danger, a licensor can immediately suspend the provider’s license; any children on the premises are sent home.

If there is an opportunity to cure the violation without placing children in danger of imminent harm, the agency encourages licensors to enter into a compliance agreement (*i.e.*, corrective action plan) with a provider.<sup>18</sup> Licensors monitor the care provider’s progress under the compliance agreement. Providers can also be fined for standards violations.<sup>19</sup>

Providers have the right to appeal an enforcement action through the administrative law system. When an appeal is filed, an ALJ reviews the agency’s action for its compliance with the statutes and regulations governing child care licensing and enforcement.

At the end of three years, a provider may apply for a license renewal. An assigned licensor reviews the application, which consists of a checklist document filled out by the provider answering questions about the way the family home child care facility is organized and operated. The licensor is required to conduct a site visit, and review the provider’s complaint and sanction history. The license is either renewed or the renewal application is denied. A decision to not renew a license may be challenged through an administrative law appeal.

### ***Timeline of Enforcement Actions***

DSHS issued a family home child care license to the Zaring Day Care in December 1991. DSHS authorized Zaring to care for six children, with only two permitted to be under the age of two. The licensing file includes a note that the initial licensor, who was fairly new at her job, had unspecified “concerns” about the provider. The licensing supervisor approved issuing the license.

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<sup>16</sup> DEL notes that “much of the time, allegations that involve child abuse/neglect also involve separate licensing violations. Licensing violations can be valid, even when CPS did not find abuse.”

<sup>17</sup> As noted above, the type of available enforcement tools has expanded over time.

<sup>18</sup> Corrective actions can include conducting repairs at the facility, attending pertinent training sessions, bringing child care records up to date, or improving communications with parents. They are designed to bring the provider into compliance with all pertinent family home child care regulations.

<sup>19</sup> Until 2004, licensors had discretion on whether to create a corrective action plan when a provider repeated a violation of standards. However, in October 2004, DSHS regulations were amended to allow licensors to fine providers whenever there were two repeat violations in a 12 month period. See WAC 170-296-0020, -0390.

Zaring's license was regularly renewed. At the time of this incident, Zaring's license had lapsed due to non-payment of fees. Because of this incident, Zaring and DSHS reached an agreement to close the facility. DSHS revoked Zaring's family home child care license on January 28, 2004.

A brief chronology of key events follows:

**First Three Years (1991-1994) (DSHS-OCCP)**

November 1991	Home inspection for license. Zaring told to remove fire extinguisher from closet; Zaring complied.
December 1991	Three-year license issued.
November 1992	Unannounced licensor visit, due to a parent's October 1992 complaint that Zaring left children in cribs all day. Licensor observed questionable hygiene (pet licked baby bottle nipple); failure to supervise children; and mowing the lawn with children at the home when they were out of sight and hearing distance. Licensor found three children under the age of two in home, an overcapacity violation of the license.
December 1992	Provider applied for and received a waiver from DSHS for the capacity violation (after the fact).
December 1994	License renewed.

**Summary:**

- One complaint, one visit with non-compliance noted, for which DSHS provided an after-the-fact waiver. Other aspects of complaint not verified or shown to be false.
- During three years, DSHS visited provider once after license issued, in response to the complaint.
- Three DSHS licensors interact with Zaring's day care.

**Second Three Years (1995-1997) (DSHS-OCCP)**

August 1995	Complaint of overcapacity. Licensor called provider, who denied it.
January 1996	Complaint of abusive discipline. CPS referral made. CPS investigated but no finding was made.
February 1996	Licensor unannounced visit to follow up January abusive discipline complaint. Found not in compliance for child supervision, safety, and fire extinguisher issues (repeat).
February 1996	Renewal license (back-dated) issued to provider, through November 11, 1997.
December 1996	License renewal visit, repeat safety issues re: fire extinguisher not placed in proper location; children had improper access to

	<p>upstairs (non-day-care area of house); inadequate supervision when children were outside.</p> <p>A week later, licensor again visited Zaring's facility, and noted, "all deficiencies corrected except for a couple." However, the licensor's report did not describe the remaining deficiencies, and approved Zaring's license renewal.</p>
February 1997	Licensor discovered provider had not paid licensing fee for 1995 and 1996, sent notification letter to Zaring, who then paid past due fees.
November 1997	Home study for re-licensing by licensor – problems identified included improper placement of fire extinguisher (repeat), upstairs smoke detector to be replaced, no locks on doors (repeat), and no art supplies available to children.
November 1997	License issued for next three years

Summary:

- Two complaints, ten incidents of non-compliance noted; eight were repeat violations that Zaring did not address. No finding made on CPS complaint. License renewal visit resulted in findings, which were mostly corrected.
- Provider technically unlicensed for two years due to non-payment of fee. Issue not addressed by DSHS.
- Three visits by two different licensors during the three years.
- One additional DSHS licensor interacts with Zaring's day care.

**Third Three Years (1998-2000) (DSHS-OCCP)**

January 1998	<p>Parent's complaint of improper discipline (yelling "shut up" at children, and slapping/grabbing children) and of failure to properly supervise children (leaving unattended in front yard while front door closed and locked) (repeat). Referred to CPS for CA/N investigation. No finding made by CPS.</p> <p>Licensor home visit on same complaint. Found three children under the age of two in home, an overcapacity violation (repeat). Zaring denied improper discipline. Children were not interviewed for this report. Zaring admitted to improper supervision.</p>
January 1998	Another complaint call with three allegations: (1) school age children were kept outside so younger children would not awaken during nap time; (2) a "big white car" would transport the older children to another house for day care during times they were supposed to be in Zaring's facility; (3) alleged injury to child, with need to seek medical treatment for child twice after picking the child up from Zaring.

	Based on these allegations, licensor conducted another unannounced site visit. Zaring denied all allegations. Licensor interviewed children and learned supervision was insufficient during outside play, as Zaring allowed children to play out of her sight. Licensor developed compliance agreement to keep children out of front yard. No waiver requested or mentioned on overcapacity issue.
February 1998	Third complaint received that Zaring slapped child for crying, and that child rode bike away from child care unsupervised.  Licensor visits home and cannot confirm whether incidents happened. Plans to conduct "monitoring visits in future." Zaring again identified as having three children over the authorized capacity (repeat).
February 1998	Parent who alleged that medical treatment was necessary for child due to Zaring's care (January 1998) never provides medical records to licensor. Complaint not verified.
May 1998	Licensor sends a follow-up letter to the January 1998 compliance agreement to Zaring because of lack of compliance with requirements of agreement.  Zaring responded two weeks later, demonstrating compliance with the agreement.
June 1998	Unannounced monitor visit – reviewed files, saw limousine pick up Zaring's children to account for overcapacity. Zaring told to improve parent communication, make art supplies available (repeat), and have immunization records updated.
July 1998	Closed January complaint file re: older children kept outside. A CPS referral was not made as it "did not meet CPS criteria."
January 1999	Fourth complaint from parent led to area licensing supervisor's unannounced visit. After discussion w/child, licensor spoke with Zaring about child's allegations that s/he sat unsupervised outside the home, babies slept all the time while they were at the house, that Zaring stayed upstairs while the children were unsupervised downstairs. Zaring denied allegations or said complaints were exaggerated. Zaring blamed accusation on conflict with parent over late pick-up of children. No licensing action taken. No CPS involvement. No compliance plan made.
August 1999	Fifth complaint by parent that her ten-month-old child was taken to an unlicensed provider (Zaring's mother, whose child care license had been revoked by DSHS in 1990) and left there without parent's permission.

November 1999	Sixth complaint by another provider about yelling at children. CPS referral made. Licensing violations found valid for nurture/care issues and valid for lack of supervision. No CPS action taken. Zaring placed on probation.
January 2000	Compliance agreement developed related to fire extinguisher in closet (repeat), no barrier for deck (repeat), play allowed in bedroom (repeat), lack of cleanliness around fire exits (repeat), failure to conduct fire drills, failure to use correct forms (repeat), no locks on downstairs doors (repeat), not disinfecting the changing pad, failure to install smoke alarms.
March 2000	License placed on probationary status for six months due to overcapacity (the August 1999 complaint), nurture/care, supervision (November 1999 complaint), and for transporting children to an unlicensed facility and leaving them there. Conditions of probation included requirements that all children were to be under Zaring's actual supervision, that she was not to use any other location for her business, and that she meet all minimum licensing requirements.
September 2000	Zaring admits that she occasionally took children to her mother's unlicensed care facility and left them there. Again placed on probationary status.
November 2000	License renewed for three years.

Summary:

- Six complaints about the provider made by parents and one other child care provider; multiple and repeat violations of the licensing laws noted. License placed on probationary status in March and again in September. However, license renewed for three years one month later, without intervening visit to provider.
- Five visits to the provider made by three DSHS licensing personnel.

**Fourth Three Years (2001-2003) (DSHS-DCCEL)**

January 2001	Compliance agreement created due to site visit. Still overcapacity (seven children, four or possibly five under the age of two). Hallway obstructed, unsafe in fire; improper fire extinguisher placement, non-operable smoke detectors. Children in bed too long. Child away from facility, at Zaring's mother's house. Outside deck still unsafe (all repeat). Zaring asked licenser for waiver on capacity.
March 2001	Probationary license issued due to leaving child at Zaring's mother's house.  License renewal visit; Zaring told to make the outside deck safe for children, to correct the placement of a fire extinguisher, and to repair a smoke detector (all repeat).

April 2001	License renewed for Zaring.
April 2001	Complaint that Zaring used her mother's telephone number for child care inquiries (mother not a licensed child care provider). Zaring again overcapacity, caring for three children who were under two years old.
June 2001	Licensors confirmed April 2001 complaint.
August 2001	Licensors send compliance agreement to Zaring based upon April violations (use of phone number and overcapacity).  No note in file that licensors verified that Zaring fulfilled the terms of the compliance agreement.
June 2003	Zaring moves to new residence. Applies for license for new location of family home child care center.
October 2003	Licensors evaluate prior complaints, identifying valid complaints for supervision (three times), business (twice), other complaints (three times) and inconclusive complaints (twice).
December 2003	Zaring completes Family Child Care Home Licensing Study form as part of process of seeking license at new residence.

Summary:

- One complaint.
- Two site visits by one licensors identifying repeat violations, and validation of 1999 complaint; one phone verification of complaint, and additional violations. No licensors visits between 2001 and processing of new license in 2003.
- One additional DSHS licensors interacts with Zaring's day care.

**Final Month of Operation (2004) (DSHS-DCCEL)**

January 5, 2004	Zaring passes criminal history background check for new license in her new location.
January 12, 2004	Zaring injures H.R.
January 13, 2004	Child taken to hospital at 4:00 a.m. Social worker files CPS complaint due to child's injuries.  Zaring Day Care closed until investigations concluded. Zaring calls DCCEL to report injury to H.R. and says child had 105 degree fever when parents dropped H.R. off.
January 14, 2004	Zaring admits injuring H.R.
January 28, 2004	DCCEL revokes license of Zaring home child care.
March 5, 2004	CPS concludes investigation as founded for child abuse.

## Overall Summary:

- Zaring operates family home child care facility for over 12 years.
- At least 11 DSHS licensors interacted with Zaring and her day care during the 12 years.

### **Seriousness of Overcapacity Violations**

Studies have identified certain risk factors related to the health and safety of children in day care facilities, which include operating a care facility with a population over its capacity, inadequate staffing, and inadequate fire prevention (e.g., Colbert, J., *Minimizing Risks to Children in Licensed Child Care Settings*, June 20, 2005, at 27<sup>20</sup>). One study discusses the dangers of overcapacity in a family child care home (Wrigley, J. and Dreby, J., *The Virtue of Dispassion: Fatalities in U.S. Child Care, 1985–2003*, unpublished research paper). Wrigley attributes the greatest risk of violence to caregivers' responses to infant crying and failure to go to sleep (*Id.*, at 24). The study notes that the main triggers for violent incidents in home-based care "involved caregiver loss of emotional control when coping with children's basic care" (*Id.*, at 26). Because it can be easier to become overwhelmed when confronted with numerous crying babies, infants are at greater risk when their caregiver operations exceed their licensed capacity.

### ***DSHS-DCCEL Personnel Debriefing***

Members of the LPRT interviewed Spokane-area DCCEL personnel, some of whom worked with Zaring Day Care. Below is a brief description of findings based on the personnel interviews and comments about the incident. The findings address the licensor training process, caseload pressures, licensor morale, and factors that negatively affect the ability of licensors to properly monitor family home child care facilities.

### **Training Issues**

Training is an exceptional loss prevention tool. When done well, training provides workers with the information and skills they need to modify workplace behavior to be more effective and efficient. Pertinent to this study, the team examined agency training procedures for licensors and family home child care providers.

### **Licensors**

DCCEL personnel indicated that during the early years of Zaring's interaction with the department, the agency provided limited training to licensing staff and to providers. In 1991, when Zaring was first licensed, DSHS put licensors to work without any prior training, and instead required supervisors to provide on-the-job feedback. Such training

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<sup>20</sup> Dr. Judith Colbert is an Early Child Care and Education Consultant. DCCEL contracted with Dr. Colbert to produce the cited study.

was less than optimal; supervisors were trained for, and focused on, foster care licensing and did not have specific child care training.

Licensors training vastly improved when the family home child care licensing responsibility was transferred to DCCEL. DCCEL personnel have adopted a robust training program, which consists of eight sequential teaching modules.<sup>21</sup> After attending a training module, licensors apply its lessons to their work in the field, and then return the next month for training on the subsequent module. The training is mandatory.<sup>22</sup>

### Providers

Provider knowledge of their business and best caretaking practices is also essential to effective loss prevention. DSHS established the State Training and Registry System (STARS) program for child care providers. Ongoing training through STARS provides a tangible benefit to children by improving the quality of child care in Washington.

Additional subsidized training is available through the Washington State Child Care Resource and Referral Network. This is a vital service, particularly because most providers have limited training budgets. However, there appears to be a shortage of subsidized training available for all family home child care workers. Because of this lack of resources, licensors are currently reluctant to require providers to obtain additional needed training. Thus, although DCCEL personnel agreed during the interviews that training today is the best it has ever been, they opined that providers do not have sufficient access to affordable training.<sup>23</sup>

### **Caseload Pressures**

DCCEL personnel believe that excessive caseload precluded sufficient monitoring visits to the Zaring Day Care, and that this was a contributing factor for the Zaring incident. This may be an accurate perception; studies show that unannounced visits are the best way to achieve child care facility safety and quality. However, it is unclear whether there are too few licensors, when compared to staff levels in other states.

Washington licensors are assigned either to homes or child care centers, but not both. Compared to a majority of states, DCCEL requires longer periods of time between provider compliance visits. Also, child care homes in Washington are licensed for a three year period, which is longer than facilities in most states.<sup>24</sup> By contrast, some states (such as Oklahoma) ask licensors to monitor both homes and centers, require

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<sup>21</sup> Each training module lasts anywhere from one to three days.

<sup>22</sup> A copy of the agency's publication outlining its licensor training program is attached as Appendix C.

<sup>23</sup> One possible way to make training more available to the providers who would most benefit from it is by using training as an interim sanction. This method has been adopted successfully by agencies in other states, such as the Tennessee Child Care Licensing authority.

<sup>24</sup> These time periods could result in smaller licensor workloads.

annual provider visits, and have caseloads of one licensor for every 50 facilities.<sup>25</sup> In general, Washington licensors do not make as many home child care visits as other state program staff with similar or higher caseloads.<sup>26</sup> Therefore, from the data available it is unclear whether Washington licensors have a heavier workload than licensors in other states.

A fiscal year 2004 internal DCCEL audit study reported that individual licensors are not being held accountable for conducting sufficient home child care visits, and licensors do not visit every provider once a year as required due to their other work-related duties.<sup>27</sup> Staff comments during interviews confirmed that licensors felt that they did not have the time or money to make unannounced visits. In Spokane, licensors said they “let go” of compliance and unannounced home visits for home child care facilities.<sup>28</sup>

In January 2004, licensor caseloads decreased after DCCEL leadership obtained federal funding to provide additional funded positions:

Year	Licensor: Homes	Licensor: Centers
1999	1:148	1:82
2000	1:138	1:82
2001	1:146	1:85
2002	1:162	1:88
2003	1:153	1:77
2004	1:122	1:64
2005	1:114	1:63

The current caseload levels are an improvement.<sup>29</sup>

### Licensor Morale

During interviews, Spokane-area DCCEL staff indicated that some providers harass them, and that some DCCEL leadership actions indirectly support the providers at the

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<sup>25</sup> By way of further comparison, the review team notes the Tennessee model. Tennessee increased the number of family home child care licensors after two children died in their facilities. There are now four times as many licensors in Tennessee as in Washington. Licensors make several visits a year, and the number of visits to a provider is calibrated to the quality of the facility (although facilities will be visited at least once a year, poor-quality facilities receive multiple visits). The system efficiently allows licensors to prioritize their workload.

<sup>26</sup> “Child Care: State Efforts to Enforce Safety and Health Requirements,” General Accounting Office Pub. #GAO/HEHS-00-28 (January 2000).

<sup>27</sup> The agency has attempted various initiatives to reduce or eliminate administrative duties for licensors. For example, criminal background checks for license applicants are now centralized so that the Washington State Patrol has the information to the licensors in the office within five seconds.

<sup>28</sup> DCCEL has provided feedback to this report, and management believe that, after the 2004 audit, licensor unannounced visits are now being carried out.

<sup>29</sup> However, one national organization suggests that adequate staffing levels require a licensor to facility ratio of 1:75. “Licensing and Public Regulation of Early Childhood Programs,” *Position Statement of the National Association for the Education of Young Children* (1998), at 6.

expense of the licensors. For example, DCCEL provides a toll-free phone number for enforcement complaints. The agency receives approximately two calls a week from providers. The DCCEL leadership staff follow-up these calls by contacting the licensor's field supervisor, who is then given discretion to address the provider's complaint. Leadership staff then contacts the provider to confirm that the licensor has been contacted, and to tell the provider what action is being taken to address the complaint. Headquarters monitors the outcome. It is unclear what affect this has on licensor enforcement behavior, but it does contribute to the perception that leadership does not support the licensors' enforcement actions.

Another example of a morale issue that can arise from agency activities occurred at a recent DCCEL conference. The theme of the conference was customer service. Both DCCEL leadership and staff identified their customer as "the child." However, the conference focused on licensor-provider relations, rather than on child safety or provider performance. This focus on the provider can affect a licensor's morale and reduce the effectiveness of enforcement actions, as well as undermine child safety in a facility.

Zaring Day Care operated above its licensed capacity for toddlers, and Zaring was placed on probation on the condition that she no longer exceeded her capacity. When Zaring did not reform her practice of serving too many toddlers, there were no other consequences for her repeat violations and it appears that licensors were not willing to revoke Zaring's license. The review team has concluded that DCCEL licensors in the Spokane area believed, correctly or not, that enforcement standards were not supported by local supervisors or at DCCEL headquarters.<sup>30</sup>

### **Licensor Functions**

It appears that part of the root cause of the incident arises from the agency practice of having a single employee – the licensor – conduct two conflicting functions: monitoring and mentoring. Monitoring involves the investigation and enforcement of existing rules, regulations, and laws; the process could result in a license revocation. Mentoring involves helping family home child care facilities to improve their services and to provide better and safer care to children.<sup>31</sup>

Issues affecting the adequacy of the licensing process can occur in the initial review of whether to approve a license application. For example, if a licensor knows that a lawyer is reviewing the application process, the licensor can be reluctant to honestly report any

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<sup>30</sup> The issue also exists in the context of a license revocation proceeding. A common interview theme was that field staff does not feel "safe" in following the department's revocation standards.

<sup>31</sup> However, for a certain period in the 1990s in the Spokane area, supervisors separated the monitoring and mentoring functions. CPS investigated complaints about facilities, while licensors performed mentoring and quality control functions. The split, in 1996, was based upon a study that found a licensor perception that family home child care facilities should not be shut down because they are needed as community resources to place children into day care. A determination was made that if investigators were independent from the licensing process, they would not be subject to community pressures to keep a poor-quality facility in operation. An added benefit of the separation of functions was the positive mentoring assistance a licensor would provide to facility operators.

Later, in a controversial decision, these functions were once again combined, and the agency required licensors to both monitor and mentor the child care providers.

misgivings about a license applicant. This reluctance could derive in part from a belief that a decision to not issue a license might not be supported by the licensor's supervisor.

Licensors in the Spokane area share a belief that once a provider is licensed, licensors face several pressures that may undermine their proper monitoring function. During their interviews, staff raised several important issues.

First, the process of investigating complaints is inherently adversarial, and an investigation can place a licensor into an awkward position. It is difficult to be a mentor to a child care provider who is also the subject of enforcement actions imposed by the identical licensor.

Second, because there is no centralized process for license revocations, licensors can receive inconsistent directives from management, which in turn makes it difficult to determine when a license should be revoked.<sup>32</sup> This uncertainty can lead to a perception that management may not support a decision to revoke a license.<sup>33</sup>

Third, at times it appeared to licensors that the lawyers assigned to DSHS wanted licensors to meet a very high threshold to obtain either a probationary license or a license revocation. One witness noted that it was easier to remove a child from a home than it was to revoke the license of a family home child care facility.

Fourth, it became much more difficult for a licensor to conduct enforcement activities because facility operators would complain to their legislators about the assigned licensor, and about the regulation process as a whole. Such complaints could quickly result in the inquiry being derailed from a concern for a child's safety to intense criticism of a licensor's enforcement actions.

Fifth, licensing staff affirmed that in the past, they have not commenced enforcement actions because of a belief that ALJs in the Spokane area had a bias in favor of child care providers.<sup>34</sup> The perception is that such ALJs required the state to prove that a care provider was actively harming children before a license would be revoked. This perception persists even though licensors are able to use civil penalties as intermediate sanctions, and therefore can develop a record of prior actions that would support a subsequent license revocation.<sup>35</sup> Currently, some licensors in the Spokane area will not institute a revocation process, to avoid an unpleasant, humiliating administrative

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<sup>32</sup> One manager believes that problems with license enforcement derive from insufficient ways of making licensors accountable for their performance, and that the manager's attempts to improve accountability were not supported by higher management.

<sup>33</sup> In addition, a revocation decision can require extensive procedural work. For example, a single revocation hearing has proceeded over a ten days period.

<sup>34</sup> Staff speculated that ALJs are reluctant to rescind a provider's business license.

<sup>35</sup> In addition, DCCEL has offered child care licensing training to ALJs in the past. However, staff pessimism persists. DEL notes that, "several child care licensing offices do not regularly use civil penalties as a compliance tool."

hearing.<sup>36</sup> Based on all of these considerations, DCCEL personnel provided the following suggestions to avoid such incidents in the future.

### ***Lessons Learned***

DCCEL staff opined that enforcement actions should be swift when there is a pattern of problems at a family home child care facility. In addition, based on the Zaring incident, certain practices should be followed: (a) if a facility moves its location and does not renew its license, it should be closed down; (b) if a facility moves its location, at least one scheduled visit to the new facility must occur; and (c) smaller caseloads for licensors would have resulted in more careful review of Zaring's history and better enforcement of applicable rules, regulations, and laws.

### ***Comparison: DSHS Adult and Disability Services Administration***

The LPRT compared the DCCEL licensing renewal procedure with that of another DSHS division that performs licensing and enforcement functions, the Adult and Disability Services Administration (ADSA). Certain elements of the ADSA system are effective, superior to current DCCEL practice, and may be easily incorporated into the renewal process.

The ADSA licenses and enforces both federal and state standards for the facilities it regulates, including nursing homes<sup>37</sup> and adult family homes.<sup>38</sup> These facilities provide medical, daily living and residential services to vulnerable adults in a variety of settings.

The ADSA requires separate staff to conduct enforcement and licensing functions. Licensors mentor providers, and make referrals to enforcement personnel when they observe a problem. Licensors do not develop the investigation, and do not impose sanctions. The ADSA license renewal procedure is efficient and avoids any licensor conflict of interest issues. All enforcement actions are centralized, and revocations are determined by staff at agency headquarters. This practice promotes consistency of enforcement of pertinent laws and regulations.

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<sup>36</sup> By way of contrast, staff in western Washington reported positive outcomes from administrative hearings. There was insufficient statistical data to determine whether the staff opinion in eastern Washington was based on solely anecdotal evidence. However, the perception clearly had a negative impact on staff behavior.

<sup>37</sup> Washington has approximately 230 nursing homes. On average, nursing home licensors work on 4-9 applications per year. Once the homes are licensed, DSHS requires inspections to occur every 12-15 months. Inspections last from 3-5 days, and are conducted by 3-5 inspectors. There is no expectation that licensors will assist in correcting problems, if deficiencies are found in the operation of a nursing home. Instead, nursing homes are expected to correct any specified deficiencies themselves.

<sup>38</sup> Currently, there are approximately 2200 adult family homes in Washington. Licensing decisions are made by an agency group that is separate and distinct from enforcement personnel (complaint investigators). Licensors are assigned approximately 72-80 homes each. Investigators have an array of tools available to obtain compliance with regulations by home operators. However, unlike the regulation of family child care homes, enforcement of regulations does not involve consultation with the Attorney General's Office. Revocations are fully within the discretion of agency staff, and are rarely overturned through administrative law appeals. It appears that there is no concern on the part of agency staff that a revocation interferes with a home operator's right to do business. As with nursing home enforcement, all revocations are conducted by agency headquarters staff, to ensure decision-making consistency.

The ADSA enforcement actions are developed by local investigators, and then referred to headquarters for review, approval and conveyance to the provider. Licensors coach and monitor the provider's compliance with the enforcement action. This practice reduces any friction between providers and local licensors, ensures consistency of enforcement in similar situations, and supports licensors in their mentoring activities.<sup>39</sup>

### *Analysis*

It appears that DCCEL staff was reluctant to require Zaring to fulfill the minimum family home child care standards set forth in DSHS regulations. The many licensors who worked with Zaring over the years repeatedly wrote corrective action plans instead of working to revoke Zaring's license for not meeting the minimum standards.

Zaring had a pattern of repeat violations and failed to meet minimum licensing standards.<sup>40</sup> Licensors found that Zaring was overcapacity during at least eight of their facility visits.<sup>41</sup> Zaring was cited at least seven times for having her upstairs fire extinguisher in the closet, making it more difficult to use it in an emergency, and at least four times for failing to repair dangerous outdoor deck rails. During a two year period, she took children enrolled in her home-based care to a provider whose license had previously been revoked by DSHS for overcapacity violations. In addition, in 2002 Zaring failed to renew her license, and had failed to pay her license fees for the two previous years. At the time of the incident, Zaring was technically an unlicensed provider.

Licensors did not consistently monitor the corrective plans they created, nor did they impose civil monetary penalties for Zaring's violations. Although probationary licenses were issued on four separate occasions, there were no follow-up visits and Zaring's license was reinstated each time without any confirmation that she had met the conditions of her probation.

Nearly one dozen different licensors responded to customer complaints of problems with Zaring Day Care. Even though most of the complaints were unfounded as a result of the home visits, licensors did discover violations that led to Zaring's probationary status. However, the large variety of licensors may have led to the lack of significant

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<sup>39</sup> The U.S. Navy uses a similar approach to that employed by ADSA and separates licensor and investigator functions. In just a few years, the Navy converted its deficient child care program into an exemplary system that is perceived to be the gold standard for such facilities. The Navy imposes comprehensive and uniform quality standards, and maintains its standards through a rigorous provider evaluation program. The Navy also uses a rigorous enforcement program.

Navy licensors mentor the care providers. However, unlike the DCCEL process, the Navy requires both a licensor supervisor and a review board to examine a license renewal applicant's entire record. Even though a licensor may have an ongoing mentor relationship with a provider, the Navy will not renew a license if reviewers find repeat violations.

<sup>40</sup> Although DSHS licensors conducted site visits when they responded to complaints about the Zaring facility, they only made one other visit during the 12 years the day care was in operation that was specifically designated as a monitoring visit (and that was separate from any complaint).

<sup>41</sup> DCCEL practice at the time was to allow a facility to continue in operation if it was one or two children over its limit, and to work with the facility to reduce the number of children through the terms of a corrective action plan. This practice arose because the agency had no specific guidelines for addressing overcapacity violations.

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follow-up, and may account somewhat for Zaring's ability to repeatedly violate the same licensing provisions without incurring more severe enforcement penalties. Furthermore, Zaring let her license lapse, but the agency did not act to compel compliance or take steps to close the unlicensed provider.

In response to these findings, the review team provides the following recommendations, which describe certain steps that DEL might take to reduce future risk to children in family home child care facilities.<sup>42</sup> The recommendations are accompanied by brief analysis pertinent to each suggestion.

## SECTION 4: RECOMMENDATIONS

Child care licensing laws are essential mechanisms for reducing risks to children. As the research literature indicated:

*Exemplary licensing systems are highly integrated with strengths in all areas. System elements are balanced, complementary and interconnected, and responsive to current needs . . . an exemplary licensing system should include effective rules, competent well-trained licensors, sufficient staff to carry out frequent inspections, and effective enforcement with consequences (Colbert, supra, Executive Summary at v.).*

Based upon our review, we provide the following recommendations, organized into four interconnected service areas: (1) licensing; (2) community outreach; (3) training initiatives; and (4) enforcement.

### **LICENSING**

#### ***Recommendation 1: Separate the licensor and enforcement functions.***

This separation is a characteristic of the successful child care systems operated by the ADSA and the U.S. Navy. It enables a licensor to effectively focus on mentoring provider development and family home child care quality control, while freeing an investigator to focus on the assessment of whether the facility is providing a safe environment for children. Superior operation of both functions would improve the quality of care, and benefit children using the facilities.

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<sup>42</sup> With hindsight, it is easy to conclude that, because the minimum standards were violated on at least eight occasions, Zaring's license should have been revoked prior to January 2004. However, it is speculative at best to conclude that the revocation would have prevented the incident. H.R.'s father had a friendship with Zaring, who repeatedly demonstrated that she would violate day care rules and regulations, and might have offered unlicensed care. In that event, had her parents used Zaring's services anyway, H.R. would still have been exposed to Zaring. However, DSHS would not have been involved.

***Recommendation 2: Implement an investigation response tracking system.***

If the intermediate sanctions imposed on Zaring had received timely review with appropriate follow-up, the injury to H.R. might have been avoided. An investigation tracking system can eliminate recurring violations by requiring staff to follow-up on a corrective action. Proper enforcement could lead to provider improvement, or to revocation of deficient provider licenses.<sup>43</sup>

***Recommendation 3: Create additional internal audit procedures.***

These procedures could include reviews of provider files to determine documentation quality, to confirm home visit frequency, and to discern whether repeat violations had been addressed.

***Recommendation 4: Update the caseload tracking system.***

It appears that, once provider quality is measurable using the investigation tracking system described in Recommendation 2, it will be useful to track the relationship between a licensor's caseload level, the investigator's field activity, and the provider's quality. This will allow the agency to assess how well the mentoring process of licensors and the monitoring process of investigators are integrated.

***Recommendation 5: Improve provider tracking systems.***

One reason that Zaring was able to continue to operate her facility was that there was repeated turnover in the corps of licensors that had her on their caseload. DCCEL should implement a system that will track facilities that have corrective action plans, have been placed on probation, or have had license suspensions. In this way, repeat violators will receive the proper degree of attention and review.

***Recommendation 6: Require annual license renewal.***

Both the ADSA and Navy child care systems require providers to renew their licenses annually. The theory underlying those programs is that annual licensing visits in addition to monitoring visits increases provider compliance with minimum standards. This reasoning applies equally to the DEL facilities, and together with the other recommended changes, would eliminate the possibility that a provider's deficient performance would continue over a number of years.

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<sup>43</sup> Currently, the agency measures the amount of time it takes to close customer complaints regarding family home child care facilities. The team suggests additional measurements should be made that compare the nature of complaints with any enforcement actions required of the provider, together with the ultimate resolution of the enforcement action. These added measurements will enable more detailed provider assessments.

***Recommendation 7: Create an automated renewal notification system.***

This system would notify the agency when providers such as Zaring failed to file timely renewals or failed to pay their license fees, further eliminating the possibility that a deficient facility would continue to operate with a license.

***Recommendation 8: Institute team review of license renewal applications.***

Team review will ensure that there is a comprehensive review of the entire enforcement history of a provider before the decision to renew is made. This will promote conditioning any license renewal on proper resolution of past enforcement actions.

***Recommendation 9: Centralize the license renewal application process.***

Centralized review will ensure a uniform process, based upon a detailed, multi-person review of the provider's complete file. If repeat violations exist, the team approach to reviewing applications will promote consistency when deciding whether to deny the renewal.

**COMMUNITY OUTREACH**

***Recommendation 10: Eliminate the current provider complaint process.***

The toll free complaint hotline is outside the administrative law process. It promotes political resolution to issues, to the detriment of the existing fair and public administrative hearing process.

***Recommendation 11: Improve parent access to provider information.***

Community perceptions of agency activity can be negative, as parents will complain if their provider is sanctioned or if the provider is closed. Currently, DCCEL discloses validated complaints and sanctions to parents through telephonic or internet systems, which can make it fairly difficult to access the information. The team suggests that in addition to the current methods of notifying the public, family home child care facilities be required to publicly post their license enforcement history and, upon request, to give parents a copy.

***Recommendation 12: Increase the amount of provider training.***

Currently, state regulations require 25 hours of training, while the Navy model requires at least 40 hours. To implement this change, training should be inexpensive. DCCEL could coordinate its training programs with the Washington State Child Care Resource & Referral Network and the community college system, and create programs that are presented to licensors at neighborhood locations or in provider homes.

## **TRAINING INITIATIVES**

### ***Recommendation 13: Licensor documentation supporting enforcement.***

With the separation of licensing and enforcement functions, it will be necessary to educate staff regarding the correct way to update provider files so that the information would be helpful in any subsequent enforcement actions.

### ***Recommendation 14: Investigator documentation supporting licensing.***

Similarly, it will be necessary to educate investigators on the correct way to generate intermediary sanctions that will promote effective mentoring by licensors.

### ***Recommendation 15: Provide regular training to ALJs.***

This recommendation requires DEL to develop an interactive relationship with the Office of Administrative Hearings. This dialog will probably include a discussion of administrative hearing trends, as well as the reasons for ALJ decisions. This training initiative will benefit ALJs and agency staff. ALJs need to have extensive awareness of child care licensing standards and practices, particularly as the system changes. With regard to the agency, improved understanding of ALJ decisions will inform the day-to-day work of licensors and investigators and would have a positive effect on licensor and investigator morale.

## **ENFORCEMENT**

### ***Recommendation 16: Require enforcement staff to work in teams.***

The use of enforcement teams will enhance the quality of provider oversight by requiring group consensus on whether a facility provides child care that meets minimum regulatory standards, whether sanctions are appropriate, and the nature and severity of sanctions imposed on the facility.

### ***Recommendation 17: Perform annual inspections.***

Annual inspections are another characteristic shared by the ADSA and Navy systems, and are directly linked to improved child care quality. The inspections may be conducted on specific subjects at different times of the year, as in the Navy system, or comprehensively once a year, as in the ADSA system. The inspections should be preceded by a complete team review of the provider's file.

### ***Recommendation 18: Create weighted compliance standards.***

Weighted compliance standards would help providers to prioritize which standards violations require the most immediate attention. Because many providers have limited resources, it would also assist their efforts to allocate resources efficiently, as well as assist investigators determine the appropriate level of sanctions to impose in a given

situation. Furthermore, such standards will clarify to agency staff, as well as the public, which violations could result in the revocation of a license.

***Recommendation 19: Emphasize enforcement of capacity rules.***

DCCEL applies a variable enforcement standard for overcapacity, by permitting a provider to seek a toddler capacity waiver for a limited period of time. If the waiver is granted, the provider is not in violation of standards. The concept is useful for providers, as it permits them to accept a toddler into care when one of their current children will soon have their second birthday. The availability of the waiver requires the provider to anticipate the overcapacity. Retroactive application of the overcapacity waiver should be prohibited, to avoid any provider having a regular practice of caring for more than two toddlers for an extended period.

# **Appendix A**

## **Licensing Qualifications and Licensing Compliance Regulations**



## APPENDIX A: LICENSING QUALIFICATIONS AND LICENSING COMPLIANCE REGULATIONS

### 1. Licensing qualifications

To have a license, a successful applicant must have:

- (a) An understanding of how children develop socially, emotionally, physically, and intellectually;
- (b) The ability to plan and provide care for children that is based on an understanding of each child's interests, life experiences, strengths, and needs;
- (c) The physical ability to respond immediately to the health, safety and emotional well-being of a child;
- (d) Reliability and dependability;
- (e) Truthfulness;
- (f) A disposition that is respectful of a child's need for caring attention from a care giver; and Ethical business practices with clients, staff, the department and the community. WAC 388-296-0140.44

The license application process, including a home inspection, must be completed within 90 days after its initiation. WAC 388-296-0250. Licenses must be renewed every three years. WAC 388-296-0260. Renewal applications must be received by the agency at least 90 days before the current license expires; the agency will "close [the applicant's] license if it expires and [the agency has] not received a renewal application." *Id.*

There are three levels of licenses that the agency may issue to an applicant: initial, full, and probationary licenses. WAC 388-296-0330. Initial licenses are provided to applicants that establish compliance with all health and safety rules, but cannot show compliance with rules governing supervision, capacity, behavior management, activity and routines, and child records and information. Initial licenses can be issued so long as the applicant provides a plan indicating how it will provide compliance with these rules. These licenses can issue for up to six months, and may be renewable for up to two years. The agency will "evaluate [the applicant's] ability to follow all the rules... during the initial licensing period prior to issuing a full license." WAC 388-296-0340.

Initial licenses may be issued when an applicant shows compliance with all of the rules listed above. However, the agency "must not issue a full license [if an applicant does] not demonstrate the ability to comply with all rules... during the period [the applicant has] an initial license." WAC 388-296-0350.

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<sup>44</sup> Now located at WAC 170-296; each section referenced is identical to the section sharing the number designation in Chapter 170-296 (*i.e.*, the text of 388-296-0140 is the same as the text of 170-296-0140).

Probationary licenses arise as a part of agency oversight of family home care providers. WAC 388-296-0440.

## **2. Licensing compliance**

The agency will notify a licensee of any violations of agency rules in writing. If the violations do not threaten the health, safety or welfare of children in the licensee's care, the agency will give an opportunity to come into compliance. The written notice to the licensee in such circumstances will include: a description of the violation with the rule that was broken; notification of what is needed to comply with the rules; the deadline for compliance; and the maximum civil fine that would be paid if the deadline is not met. WAC 388-296-0360. Sanctions for violations may include actions against a license such as probation, suspension, and revocation. *Id.* If a facility violates applicable regulations in such a way that the health, safety or welfare of children in its care is threatened, DSHS is also authorized to summarily rescind the license.<sup>45</sup>

Probationary licenses may be issued when there is:

- (a) Intentional or negligent noncompliance with the licensing rules;
- (b) A history of noncompliance with the rules;
- (c) Current noncompliance with the rules; and
- (d) Any other factors relevant to the specific situation.

WAC 388-296-0440. Licenses will be denied, suspended or revoked when a licensee:

- Demonstrate[s] that [the licensee] cannot provide the required care for children in a way that promotes their safety, health and well-being....
- Has been disqualified by [his or her] background check...
- Has been found to have committed or have allowed others to commit child abuse, child neglect or exploitation, or [has or has allowed those under the licensee's supervision to] treat, permit or assist in treating children in [the licensee's] care with cruelty, or indifference.
- Fails to report instances of alleged child abuse, child neglect and exploitation to children's administration intake or law enforcement when an allegation of abuse, neglect or exploitation is reported to [the licensee].
- Or anyone residing at the same address as [the licensee] had a license denied or revoked by an agency that provided care to children or vulnerable adults.
- Tried to get or keep a license by deceitful means, such as making false statements or leaving out important information on the application.
- Commits, permit[s] or assist[s] in an illegal act at the address of [the] child care business.
- Uses illegal drugs, or excessively use[s] alcohol or abuse[s] prescription drugs.

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<sup>45</sup> WAC 170-296-0360.

- Knowingly allow[s] employees or volunteers with false statements on their applications to work at [the licensee's] facility.
- Repeatedly lack[s] the required number of qualified staff to care for the number and types of children under [the licensee's] care.
- Repeatedly fail[s] to provide the required level of supervision for a child in care.
- Repeatedly care[s] for more children than [the licensee's] license allows.
- Refuse[s] to allow [the agency's] authorized staff and inspectors requested information or access to [the licensee's] licensed space and premises, child and program files, or staff and children in care.
- Is unable to manage the property, fiscal responsibilities, or staff in [the licensee's] facility.
- Goes beyond the conditions of [its] license by caring for children with ages different than [its] license allows.
- Repeatedly fail[s] to comply with the licensing requirements of WAC 388-296 or of any provision of RCW 74.15.

WAC 388-296-0450, 388-296-0460.



# **Appendix B**

## **Agency Manuals – Practices and Procedures**



## APPENDIX B: AGENCY MANUALS – PRACTICES AND PROCEDURES

### 1. 1984 DCFS Manual

In 1984, licensing of child services was overseen by the DSHS Division of Child and Family Services (DCFS). Purposes of the licensing function included:

- To safeguard the well-being of children.... who receive care away from their own homes.
- To provide consultation to applicants/licensees by interpreting licensing requirements and procedures, providing information and alternatives for attaining and maintaining compliance with licensing requirements, and keeping licensees informed about changes in licensing requirements and procedures.
- To provide consultation to agencies (licensees) in order to help them improve their methods of and facilities for care (beyond the level established by licensing requirements).

DCFS Manual, Ch. 6, at 6. To effectuate these policies, the manual required that the minimum safety standards would be “uniformly applied and maintained statewide.”

*Id.*, at 8. It defined the licensing role to be:

- To license agencies known to be in compliance with standards;
- To investigate complaints;
- To provide information to assist agencies in attaining and maintaining compliance;
- To take negative action in the form of denials of and revocations of licenses from agencies that do not meet, or that fall below, minimum standards; [and]
- To provide information related to changes in licensing regulations or procedures to licensed facilities.

*Id.*, at 9. The authors of the manual warned that enforcement of the licensing standards must be consistent:

- If individual licensors are free to interpret rules differently and to informally waive various requirements, an inequitable system results. For these reasons, the waiving of requirements shall occur only through a formalized process subject to administrative review.

*Id.*, at 10. Within this context, proper enforcement requires a balancing of the interests of all involved in child care, although the interests of the child remain paramount:

- The basic purpose of licensing is to protect and promote the welfare of persons in the care of licensed facilities. At the same time, the rights of licensees must be respected. In cases in which there is conflict between these two interests, the department will opt for the best interests of the person in care. (Licensees have a right to a hearing concerning departmental decisions which affect them adversely.)....

*Id.*

## **2. 1997 OCCP Manual**

In 1987, the legislature created the Office of Child Care Policy (OCCP) in order to improve the quality of child care services. In 1994, OCCP became the centralized agency overseeing all child care licensors in Washington, in order to create “a better link between licensing and overall state efforts to improve child care services and systems.” 1997 OCCP Methods and Practices Manual (Manual), at 1.

The Manual states that OCCP has specific roles and responsibilities, including:

- To develop standards and regulate child care homes and centers.
- To increase the supply of high-quality licensed child care by . . . [f]acilitating recruitment and training efforts.

*Id.*, at 2-3.

With regard to the balancing of interests between a child’s care and the child care provider, the Manual states:

- Changes in the licensing law make it clear that OCCP’s first responsibility is the health, safety, and well-being of children. As the people responsible for inspecting and licensing child care facilities, licensors must make difficult interpretations in enforcing child care regulations; sometimes this means enforcing rules that weren’t enforced in the past.
- Where there is a pattern of non-compliance with Minimum Licensing Requirements, and the licensor has worked with the provider to come into compliance, the licensor may suspend or revoke a child care license. The regional manager and the Office of the Attorney General must be consulted prior to such action. Where the health, safety, or welfare of a child is at risk, the licensor may also act to summarily suspend or revoke a license. A summary suspension may be done without first issuing fines or probationary licenses.

*Id.*, at 5. However, in the context of enforcement, the OCCP Manual introduced several “customer service” principles that were to guide the process of investigating complaints against child care providers:

- **Clear expectations...**includes giving providers a copy of the checklist ahead of time so providers know what the requirements are and have the opportunity to fix things before licensors get to their facility for the inspection.
- **Listening.** Through compassionate listening, it's usually possible to determine what is important to a person and to figure out a mutually agreeable solution . . .
- **Responsiveness...**involves such things as returning telephone calls as quickly as possible, taking personal responsibility for following through, keeping appointments, etc. Keeping promises is essential.
- **Fairness...**we can expect to know the rules and that they will be administered with an even hand...
- **Respect...**It's about honoring people's rights to their feelings or choices even if we disagree with them. It's about realizing that licensors may not feel powerful but may appear so to providers.

*Id.*, at 5-6.

As to the initial licensing decision, the Manual indicates that any "person who applies for a child care license and meets the minimum licensing requirements of the program is entitled to a license." *Id.*, at 13. The Manual discusses particulars regarding initial license eligibility, as well as subsequent remedial measures including corrective actions, suspension, and revocation of licenses. *Id.*, at 29-58.

### 3. 2001 DCCEL Manual

In 2001, OCCP was consolidated into the DSHS Division of Child Care and Early Learning (DCCEL). DCCEL licensing activity included:

- Licensing over 2,000 child care centers and 7,200 family child care homes;
- Re-licensing facilities every three years and monitoring at least once between licensing periods;
- Monitoring child care centers at least once a year; and
- Carrying an annual workload of:
  - Over 2,300 new license applications
  - Approximately 40,000 criminal history checks;
  - Approximately 5,000 complaint investigations;
  - Monitoring each month approximately 300 probationary licenses issued to providers who are chronically non-compliant; and
  - Preparing for court hearings for over two dozen revoked or suspended licenses.

The policies and procedures governing the initial licensing decision and subsequent enforcement actions remained relatively unchanged from the 1997 Manual.



# **Appendix C**

## **DCCEL Staff Development and Training Program Report**



[http://www.del.wa.gov/Education/Licensor%20Core%20Training%20report606%202\\_.pdf](http://www.del.wa.gov/Education/Licensor%20Core%20Training%20report606%202_.pdf)