HB-1382 BEXLEY'S LAW

FEBRUARY 27, 2022

BEXLEY ALICE ROVINSKY

06/15/20 – 02/09/21

Age: 7 months and 21 days old

Height & Weight:

Growth: 99th percentile

Favorite Food: Just about all veggies, cooked but not pureed

Favorite Toys: Mr. Moo cow, Peek-a-boo pop-ups, giraf-fa-fa, and her sister's pink Trolls microphone

Milestones: 5 ½ mo. - mama; 6 mo. – dada; 7 mo. – cruising, baba (bottle); ah-boo (peek-a-boo)

Who was Bex?: Bexley was sunshine, snuggles and smiles, as long as she wasn't hungry. She had a hearty laugh, or as Elise calls it "an old man laugh". Our sweet baby girl, a beloved little sister. She adored her big sisters, and Kylie had so many plans for her and Bex.

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BEXLEY'S LAW

OVERVIEW

Bexley's Law is named for our youngest daughter, Bexley Alice Rovinsky. On February 9th, 2021, she was "found unresponsive" while at the daycare she attended with her four-year-old sister Kylie. EMS worked on Bexley at the daycare, continued while transporting her to the hospital, then every Doctor and Nurse they could fit in to her room tried everything they could, but it was too late, our Bexy was gone.

The purpose of Bexley's Law is to improve safety and accountability for infants in a childcare setting. The core of our efforts are focused on improved infant sleep checks and monitoring systems, care and technology. Through our endeavors we hope to be able to increase infant safety and give peace of mind to both parents and caregivers.

BEXLEY'S STORY

Just like any other workday our two younger daughters went to daycare, and at the end of the day one of us would rush back to scoop them up and get our hugs and kisses. Unfortunately, this day wasn't like all the others, at 12:47pm on February 9th, 2021, I received a call from daycare, telling me that Bexley was "found unresponsive" and that EMS was there and working on her and that they would be transporting her to the hospital. Our provider kept saying" I'm so sorry" and "I don't know what happened". I hung up with her called my husband who was thankfully working from home that day and told him to get to the hospital. He had all these questions that I had no answers to, he bolted to the hospital, and so did I. We both arrived before the ambulance got to the hospital and had to wait for someone to figure out where the ambulance was, if it was still coming there or did they decide to take her to another nearby hospital. I just remember sitting in that waiting hugging my husband, rocking back and forth saying "my baby, where is my baby" over and over. I couldn't tell you how long it was before a nurse came out "to prepare us" for what we were going to walk into. We would have stood on hot coals to stay by her side. There was our Bexy, laying on the gurney, with tubes and wires

MARYLAND STATE CHILD FATALITY REVIEW TEAM

Sudden Unexplained Infant Deaths in Maryland SUID is the sudden death of an infant less than one year of age that cannot be fully explained after a thorough review of the medical history, a complete autopsy, and examination of the death scene. Approximately 3,600 infants die suddenly and unexpectedly each year in the United States. The majority of these deaths occur while the infant is sleeping in an unsafe sleep environment and could have potentially been prevented if safe sleep practices were always followed. Key components of a safe sleep environment are placing infants to sleep alone, on their backs, on a firm sleep surface with no soft objects, and in a smoke-free environment. While an exact cause of death cannot always be determined, unsafe sleep factors are present in a majority of cases. **These deaths are often not witnessed, *the death scene may be disturbed before it can be examined,* key facts may be forgotten or go unreported, and there may be no autopsy finding or medical test to prove the exact cause of death (e.g., suffocation).**
https://health.maryland.gov/phpa/documents/Health-General-Article-5-704(b)(12)-Maryland-State-Child-Fatality-Review-Team-2018-Annual-Legislative-Report.pdf

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BEXLEY'S STORY CONTINUED…

everywhere, but her glow/spark/sunshine was missing. There was as many nurses, doctors, assistants, and paramedics as they could possibly fit in that room. They worked and worked on our girl, I know they did everything they possibly could to bring her back to us, we watched every moment of it, we stood there trying to give her our strength, silently begging, pleading, to any and every entity that could possibly hear our prayers and pleas to save her, we would have traded places with her in a heartbeat. Eventually and reluctantly the Doctor had to call her time of death, our girl couldn't be saved. All the staff cleared out to allow us time with our daughter, other than a brief time where they needed us to go answer question about home life, health, development, and her daycare, during which an officer stayed in her room to guard her while we answered questions. When we came back the officer stepped back out and we were once again told to take all the time we needed, there would never be enough time. I'm not sure how long we sat there holding onto her crying, kissing her, talking to her as her colored drained and her skin grew colder. Even knowing her vibrant life was gone the idea of leaving her was gut-wrenching. The only thing that was able to get us up off that floor was that her sisters needed know and needed us to come home. We had to ask the Officer guarding her room to step inside her room again, I just couldn't walk out seeing her alone in there, he promised his job was to stay right there and guard her until she was transported to the Medical Examiner in Baltimore.

When we arrived home, we were on autopilot, numb in a complete fog. My niece had come and scooped up our seventeen-year-old, Elise, to look after her and keep her occupied. My sweet friend Erin was at our house waiting for us, my Parents brought Kylie home and my husband's sister and brother-in-law came to stay the night. Kylie was there when her sister was "found unresponsive", she was there when the Medics worked on her sister and eventually took her away. She was scared and heartbroken, she was crushed that she didn't even get to hug her sister goodbye. When Kylie came home and Bexley wasn't there, she knew it was bad, and when we asked her if she was ready to talk about what was going on or if she had questions, she said "I know, but I'm not ready yet. Having her aunt and Uncle there gave her a good distraction as my Husband, and I tried to keep it together as best we could at least until she fell asleep. We slept on Kylie's floor that night unable to sleep in our own room and wanting to be there incase Kylie needed us.

The next 10 days were a complete blur as we prepared for our daughter's service. You aren't supposed to say goodbye to your children, you're supposed to watch them grow and make memories. We miss our sweet Bexley Alice every minute of every day.

SIDS/SUID

In the last several years, the terms connoting sudden infant death have become confusing, not only to parents, but also to professionals and researchers. CDC in an attempt to clarify the issue, suggested that SUID (Sudden Unexpected Infant Death) be used as a broad term that encompasses all sudden infant deaths. This would include SIDS (Sudden Infant Death Syndrome), accidental deaths (such as suffocation and strangulation), sudden natural deaths (such as those caused from infections, cardiac or metabolic disorders, and neurological conditions), and homicides. Some others however, use SUID to mean Sudden Unexplained Infant Death. Other medical examiners might call these "undetermined" and others would still call them SIDS. ***Since there is usually no way to tell the difference between suffocation and SIDS at the autopsy, the scene investigation is of utmost importance.***

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QUESTIONS

So, what happened to Bexley?? After waiting 11 months and two days we finally received the medical examiner's report, listing her death as SIDS, but noting an atypical sleep environment. Yes, you read that correctly, and while we understand COVID has thrown a wrench into every process out there, this is absolutely not acceptable. Can you even imagine what it feels like to not know, wondering if there was an underlying condition that nobody knew about, was daycare negligent, the phrase her daycare provider used, saying she was "found unresponsive" weighs on us. What happened that day? When was she last checked on? How long was she down for? Did we as her parents miss something? What was atypical about her sleep environment? We have so many questions, but we can't get answer. Our Trooper called monthly for updates and in the beginning he was able to get, around month six the Medical Examiner's office stopped retuning the trooper's calls for well over two months. To the point that the trooper was planning to make the hour drive and show up in person to get answers. When we finally heard back, we were told the report was pending, it still took another two months for the medical examiner to give his findings. Here we are, now still waiting on answers to what was atypical?

MISSION

Bexley's Law wants to push for changes in our childcare facilities, we want to see more safety measures and ways to prove accountability. We want to see that sleeping checks are happening on schedule all the time, we want parents to have peace of mind/proof that this is happening, we want childcare providers in the face of incidents to be able to prove they did everything necessary.

1. Video recording systems should be mandatory in all daycares, in any area where children will eat, sleep or play. Video systems must be kept in good working order and recordings kept for a minimum of 30 Days,
2. Infant monitors
3. Communication

    1.) In Maryland a sleeping infant in childcare facility is supposed to be checked on every 15 minutes. According to Medlineplus "time is very important when dealing with an unconscious baby who is not breathing. Permanent brain damage begins after only 4 minutes without oxygen, and death can occur as soon as 4 to 6 minutes later." yet we are only checking on them every 15 minutes. How often are these checks not happening,

MARYLAND MEDIA REPORTS

2021 – Essex, MD – Injury of 5yr old
Saldino's Kiddie Cottage Child Care
-Parents not initially notified, video footage showed teacher yanked child to the ground by her leg, then both arms grabbed and screamed into her face.
Article:https://baltimore.cbslocal.com/2021/07/27/our-jaws-dropped-essex-daycare-teacher-caught-on-camera-yanking-child-to-the-ground/

2019 – Berlin, MD – Injury of 3yr old
Eastern Shore Early Learning Academy
-Witness reports of provider picking up child, purposely dropping on ground where child hit head. Video surveillance later revealed a second incident between child and provider that day.
Article:https://www.delmarvanow.com/story/news/local/maryland/2019/03/16/eastern-shore-early-learning-academy-employee-child-abuse-worcester-sheriff-sandy-buckwalter/3184789002/

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MISSION CONTINUED…

our providers are human and usually watching multiple children who are not on the same schedules. Distraction, mistakes, and accidents happen, most of the time things will probably be ok, but not always. When an issue does arise, whether it's an injury or death, seeing what happened or being able to prove if checks were done of if something else happened are valuable tools. A phrase that will haunt me forever "found unresponsive", Bexley was found unresponsive, and without any sort of video surveillance we have no way of knowing just how long she was unresponsive for, and of course a provider will say they did 15-minute checks. But did they, could Bexley have been saved? Or how many instances have there been in recent years where a provider has harmed a child and it was caught on surveillance and what about all the kids whose facilities do not have surveillance who is watching out for them? Facilities should be required to keep systems running at all times while children are being cared for and at least a two-week video log. Failure to having working systems and logs will need to have a warning/punishment system, but a down/wiped system during an incident could be considered negligence. Non-delete video systems should be inspect at regular inspection and treated as safety equipment.

3.) Infant monitors, a useful tool to help be a second set of "eyes", ***NOT*** a replacement for provider 15-minute checks. A provider will still be required to continue their 15-minute checks for position, skin color, breathing, and body/room temperature. If it only takes 4 minutes for a respiratory distressed infant to suffer permanent brain damage and 6-8 minutes for death, then there needs to be some way to help alert providers if there is in issue before the next check or it could be too late. First, we understand that there will always be instances that no matter how many safeguards are in place that the life will still be unsavable. Secondly, I know where the arguments will go immediately to monitors haven't shown any evidence in regard to preventing a SIDS loss. I hear you but, infant fatalities happen for other reasons then SIDS, how many times has an infant been left on tummy time to long and became distressed? Older infants are curious, leave something in their reach accidentally and they could get entangled or get ahold of a choke

MARYLAND MEDIA REPORTS

(https://www.baltimoresun.com/news/investigations/bs-md-rocket-tiers-closed-20170815-story.html, n.d.)Article:https://www.baltimoresun.com/news/investigations/bs-md-rocket-tiers-closed-20170815-story.html

2016 – Rockville, MD – Fatality of 6mo old Little Dreamers Creative Learning Center -Provider stated he tried to feed the infant but she started choking and vomited multiple times, her lips turning blue and called the ambulance. Infant was taken to the hospital where doctors found multiple injuries, bleeding in her skull and rib fracture.
Article:https://www.fox5dc.com/news/day care-operator-charged-in-death-of-6-month-old-who-suffered-cracked-ribs-broken-limbs

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MISSION CONTINUED…

hazard. The "Back to sleep" campaign has made wonderful strides, but people can still make mistakes and put an infant in an unsafe sleep situation. Not just at childcare providers, but at home too, there are countless post by regular people, parents just trying to do their best and an accident still happens, like a mom who fell asleep breastfeeding on her side and her child's face became pressed up against her, thankfully her wearable monitor went off and mom woke up and their story got a happy ending. The technology is far more advanced than thelast time the AAP updated their recommendations and data cites. The problem with SIDS data is that there is no way to predict which infants are risk. Again, these monitors are not a replacement for the physical 15-minute sleep checks, this is in addition, and extra layer of possible alert. With the previously mentioned video monitoring to ensure those checks are done, even better.

4.) Communication, the immense grief felt by families (and providers) after the loss of a child is unfathomable. Then add waiting for answers, feeling in the dark, second guessing every decision leading up to that day. *Communication*, these situations are delicate and difficult but communicating timelines/processes leading up to results would go a long way in the grieving, mental health, and patience with the process. We have had excellent communication from our social worker and the trooper handling our case, our trooper called the Baltimore medical examiner's office approximately once a month for an update. At first, he would get an update about which step they were working on, or pathology results they were waiting to come back. Around month 7 our trooper was no longer getting his messages returned, this went on for over two months, to the point that our trooper was preparing to drive an hour to Baltimore and show up at the medical examiner's office. Thankfully, he finally got a call back, and was told report was pending in November, it would still be two months until it was finalized. COVID effected world, but better communication could have helped, instead when the medical examiner's office started to ghost our trooper, we were left to wonder was something wrong, did they lose/misplace something, did she get forgotten. It makes it hard to trust the results when you have those thought in

MISSION CONTINUED…

your head. Even now after getting her result, SUID, Sudden Unexplained Infant Death, there was a notation about atypical sleep environment, I have been trying for two months to get clarification on what was atypical. It took my Delegate Hornberger backing our emails to even get a response, but even then, they still didn't clarify what was atypical. Communication and transparency can be all the difference in trusting in a diagnosis, especially in a diagnosis of exclusion.

LINKS

https://medlineplus.gov/ency/article/000011.htm
https://undark.org/2021/05/24/sids-monitors-may-not-prevent-sids/
https://pediatrics.aappublications.org/content/pediatrics/106/2/295.full.pdf
https://www.snuza.com/blog/mhra-rules-for-baby-movement-breathing-monitors/
https://safetosleep.nichd.nih.gov/safesleepbasics/SIDS/Common

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