



**Testimony of Daniel Kass, Deputy Commissioner**

**Division of Environmental Health**

**New York City Department of Health and Mental Hygiene**

**Before the City Council Committees on Health and General Welfare**

**On**

**Coordination between DOHMH and ACS Regarding Child Care Center Inspection  
and Monitoring**

**November 10, 2011**

Good morning Chairpersons Arroyo and Palma and members of the Health Committee and Child Welfare Committee. My name is Dan Kass, and I am Deputy Commissioner of the Division of Division of Environmental Health. Here with me today is Frank Cresciullo, Assistant Commissioner of the Bureau of Child Care. Also joining us is Pamela Lee, Assistant Commissioner of the New York City Administration for Children's Services, Office of Special Investigations. We are here today to provide the Committees with general information about how our agencies regulate safety in child care settings, how we collaborate, and to discuss the circumstances of the tragic case of Jeremy Davila, a four month old who died while being cared for at a regulated child care center.

The Health Department regulates child care centers within the five boroughs of New York City through its Bureau of Child Care. The Bureau permits, regulates, and monitors 2,100 child care centers, inspecting each site on an annual basis. The Bureau also provides licensing and inspection services for 9,100 State regulated home based and after school child care programs, by way of a contract with the State Office of Children and Family Services.

The Bureau of Child Care conducts approximately 26,000 inspections on an annual basis for City and State regulated child care services. The onsite field inspections assist the Bureau in determining each program's compliance with the Health Code, identifying deficiencies in program operation, and issuing citations for such deficiencies. When Bureau staff identify an unsafe condition for children that cannot be immediately remediated by the program, such as lack of egress or inadequate staff to child ratios, the Health Department issues a suspension order resulting in the temporary closure of the identified program.

In FY11 the Bureau conducted approximately 7,000 center-based inspections, 44% of which resulted in the citation of one or more violations. Often, these violations are corrected quickly by the programs, and are relatively minor with respect to child safety and health. These may include not having all up-to-date medical clearance forms, other recordkeeping concerns or minor violations of hygiene. During Fiscal Year 2011, the Health Department suspended the permits of 50 child care centers, representing about 2% of City regulated sites.

The Bureau also works closely with the Administration for Children's Services when an incident at a child care service is suspected of being caused by abuse or neglect and results in the filing of a New York State Central Register Child Abuse and Maltreatment report. The joint Health Department/ACS Office of Special Investigations Protocol describes the ways the agencies collaborate on such investigations. The Bureau and ACS's Office of Special Investigation share information on cases, work to conduct joint interviews when feasible, and provide each other with the outcomes of their respective review of the State Central Register report allegations.

The work of the Department and ACS is complementary in that ACS investigates specific incidents reported to the State Central Register and the Health Department inspects the programs' operations in relation to the incidents. While there are common aspects to our roles, such as interviews and the collection of documentation, our roles are intended to be complementary and not duplicative. The Health Department's focus is on determining whether the program's operation contributed to the

alleged incident and whether it was in compliance with regulatory requirements of the Health Code at the time of the incident. If a program has demonstrated significant non-compliance with the Health Code and these violations may have contributed to the incident, the Health Department evaluates whether there are continuing conditions that pose risks for children. When risks are found, the Health Department may suspend the program's operation.

ACS evaluates the circumstances of each incident for which an allegation of abuse or neglect has been made to see if the allegations can be substantiated. It is important to point out that the standards by which the two agencies make their determinations are somewhat different. State law requires ACS to determine whether there is credible evidence to substantiate the reported allegation. The Health Department evaluates the circumstances of each incident to determine whether the program was complying with the Health Code and whether the program can continue to operate safely. At times we do arrive at different determinations, given the nature of our roles, rules, and standard of evidence needed to make a determination.

The tragic case of Jeremy Davila came to the attention of the Health Department's Child Care Bureau on March 25, 2011 by way of a phone call from the program operator. The program operator contacted us within two hours of discovering Jeremy's condition, as required by the Health Code, and informed us the child was found not breathing and unresponsive at approximately 5:30pm while believed to be sleeping. The program staff reported that they immediately called emergency services and the police. While awaiting emergency services, CPR was performed on the child by a parent who was a trained EMT. Despite resuscitation attempts by this parent and the emergency medical services when they arrived, he was not able to be resuscitated.

The medical examiner's office later determined that the child died of "natural causes", but as is frequently the case with the unexplained death of an infant, the office was unable to identify a cause of death. During a subsequent conversation with the Medical Examiner, the Health Department was informed that the manner of death was determined to be natural as there were no signs of abuse or maltreatment, or identification of any disease that resulted in the child's death. Neither EMS, on-site police officers, the program staff and director, the Health Department's inspectors or the Medical Examiner had cause to suspect foul play or maltreatment in this case. As sad as it is for an infant to die, the absence of a clear explanation for why a death occurs only compounds the agony. As inexplicable as it sounds, sometimes an infant stops breathing while asleep without a known cause.

This incident occurred on a Friday evening. The Bureau of Child Care began a series of inspections the following Monday, the next day that children were present at the center. Those inspections reviewed staff clearances, qualifications, and adherence to training requirements. In addition, the Bureau assessed the staff-to-child ratios in place on the day of the incident, whether line-of-sight supervision of the infants was maintained at all times, and the staff response once Jeremy's condition became known.

The Bureau determined that at the time of the incident two staff were present in the infant room with a total of three children. The staff were both trained in CPR and first aid, and both were

cleared and qualified. The staff ratio in the infant room at the time of the incident exceeded the requirements of the Health Code of one staff to four infants. The staff maintained line-of-sight supervision of the infants. Therefore, staff were found to be in compliance with the supervision requirements of the code.

The Bureau did not refer the case to the State Central Register of Child Abuse or Neglect, nor did any other City agency on the scene, including the New York Police and Fire Departments. We did not make a referral because we did not have a suspicion of abuse or maltreatment. The medical records from Richmond University Medical Center indicate that a hospital social worker contacted the State Central Register of Child Abuse and Neglect to refer the case. However, absent any allegation of abuse or maltreatment, the records state that the case was not accepted by SCR. The infant's mother contacted the Bureau on April 12<sup>th</sup> and during the course of her conversation stated that she believed the program staff failed to provide adequate supervision of Jeremy while he slept. The Bureau then informed Jeremy's mother that she should report the allegation to the State Central Register, and provided the mother with contact information.

The filing of the State Central Register report initiated the protocol which requires the exchange of information between ACS and the Health Department. After the report was made, the Health Department had ongoing communication with ACS about the incident, and field responses from both agencies were initiated.

Following the initial inspection, the Bureau required the program to submit a corrective action plan identifying the steps it would take to enhance the supervision of infant and toddlers in its program, specifically while children sleep. The Health Code requires the submission of a corrective action plan in all child fatality cases, even when there is no evidence of abuse or neglect.

The child care program worked directly with the Bureau on the development of the plan and initiated a system of checking sleeping infants at 15 minute intervals and recording their observations starting March 29, in advance of the Health Department's formal approval of the corrective action plan. These changes are more stringent than what are required in the Health Code. Following receipt of the Medical Examiner's report and ACS's investigation findings, the Health Department issued final approval of the program's written corrective action plan in October 2011.

Now I'll turn to Assistant Commissioner Pamela Lee, who will describe ACS's role and findings in this case.

(ACS Testimony)

As you have heard, ACS found in its investigation evidence of inadequate guardianship because the employees did not physically inspect the child during a three hour period. However, the staff were present and maintained line-of-sight contact. About 90 minutes after Jeremy began his nap, the teachers discussed whether to wake him. But because he had slept for a shorter period of time than usual in the morning, the teachers decided to let him sleep longer than normal in the afternoon, according to teachers interviewed by the Health Department during its investigation.

This child's death and the program assessment conducted by the Bureau of Child Care has prompted the Health Department to review Health Code requirements pertaining to the care of children less than two years of age in our child care system.

We are, for example, considering whether the procedures in the corrective action plan requiring regular sleep checks recording observations such as breathing patterns, coloration, and position of each child could be the basis for a new requirement in the Health Code that applies to all facilities. While such a process may not prevent the death of a child who stops breathing, it would add an additional level of oversight to infant toddler programs.

Currently the Department maintains a website that programs and parents can use to find the results of our inspections at child care centers. The site posts identifying information for all permitted programs, and lists each violation found during inspections over the previous three years. We are evaluating how best to enhance the current profile of individual programs on our website with historical performance around child safety and supervision. We are also considering how the Health Department and the child care centers can better inform parents that this resource exists.

Thank you for this opportunity to testify. We are happy to answer questions you may have.