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DEPARTMENT OF HUMAN SERVICES
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April 4, 2017

TO: The Honorable Representative Sylvia Luke, Chair
House Committee on Finance

FROM: Pankaj Bhanot, Director

SUBJECT: **SB 522 SD1 HD1 – RELATING TO HUMAN SERVICES**

Hearing: Tuesday, April 4, 2017, 2:00 p.m.
Conference Room 308, State Capitol

DEPARTMENT'S POSITION: The Department of Human Services (DHS) acknowledges the efforts of the Legislature, community members, and advocates to seek measures to prevent the tragic deaths associated with sudden unexpected infant deaths and sudden infant death syndrome. DHS has addressed these concerns, and pursuant to Chapter 91, Hawaii Revised Statutes, promulgated amended administrative rules, effective February 24, 2017. Consequently, we provide comments that the measure as drafted is no longer necessary, and respectfully request that the measure be deferred.

PURPOSE: The purpose of SB 522 SD1 HD1 is to strengthen the safe sleep policy for child care facilities for children one year of age, including requiring placement of children on their backs for sleeping and establishing notice and annual training requirements; requires such facilities to report death of such a child, employee, or household member, within one day of occurrence, to DHS. The Senate Committees on Commerce, Consumer Protection, and Health and Ways and Means amended the measure by:

- (1) Inserting language to clarify that a safe sleep policy shall require each child care facility to ensure that any child less than one year of age is placed on the child's

back to sleep, unless written instructions are on file at the child care facility from a healthcare practitioner indicating an alternate sleep position;

- (2) Inserting the term “provider” to replace the term “operator” in regard to referencing a child care facility;
- (3) Deleting language that required DHS to conduct safe sleep training and replacing it with language that:
 - a. Requires all employees, household members, and volunteers of a child care facility to complete upon hire, and annually thereafter, training in safe sleep practices that is approved by DHS; and
 - b. Requires each child care facility to maintain a record of trainings completed;
- (4) Inserting language to specify that every child care facility shall report to DHS, within one working day of occurrence, the death of a child, employee, or household member, and any illness or injury received at the child care facility that results in a child’s hospitalization.

The House Committee on Human Services amended the measure by changing the effective date to July 1, 2090.

The primary focus of the DHS child care licensing program is on the health and safety of all children in child care. On January 4, 2017, the department issued the proposed amendments to Hawaii Administrative Rules (HAR) §17-891.1 Registration of Family Child Care Homes and §17-895 Licensing of Infant and Toddler Child Care Centers. The public hearing for the proposed rules occurred on February 6, 2017. Written comments and oral testimony were provided at the public hearing. The comments and testimony received were given full consideration by DHS prior to the adoption of the amended rules, which are effective February 24, 2017.¹

The adopted rules for registered family child care homes and licensed infant and toddler child care centers address the concerns of the Legislature and community advocates. These amendments to the administrative rules address the legislative proposals found in

¹ See the amended rules at: <https://humanservices.hawaii.gov/wp-content/uploads/2017/02/17-891.1-FCC-homes-amendments.pdf>

Section 1, subsections (b), (c), (d), and (e) of the bill. The rule amendments are also more comprehensive than the changes included in the proposed bill.

DHS respectfully requests that the measure be deferred or that the proposed sections (b), (c), (d), and (e) of this bill be deleted, since all of the proposed amendments are now addressed in the Department's administrative rules. If these proposed changes are made part of the Hawaii Revised Statutes, any subsequent substantial changes to safe sleep policies or practices, would require statutory amendments before the administrative rules could be amended. As the body of knowledge related to sleep related deaths advances, the administrative rule process allows DHS to accommodate any changes to best practices and standards of care that may occur in the future.

Thank you for the opportunity to provide testimony on this bill.

From: mailinglist@capitol.hawaii.gov
Sent: Monday, April 3, 2017 10:47 AM
To: FINTestimony
Cc: troywurtz@yahoo.com
Subject: *Submitted testimony for SB522 on Apr 4, 2017 14:00PM*

SB522

Submitted on: 4/3/2017

Testimony for FIN on Apr 4, 2017 14:00PM in Conference Room 308

Submitted By	Organization	Testifier Position	Present at Hearing
Troy Wurtz	Individual	Support	No

Comments:

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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From: mailinglist@capitol.hawaii.gov
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To: FINTestimony
Cc: wumipeg@yahoo.com
Subject: *Submitted testimony for SB522 on Apr 4, 2017 14:00PM*

SB522

Submitted on: 4/3/2017

Testimony for FIN on Apr 4, 2017 14:00PM in Conference Room 308

Submitted By	Organization	Testifier Position	Present at Hearing
Wendy Umipeg-Wurtz	Individual	Support	No

Comments:

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From: mailinglist@capitol.hawaii.gov
Sent: Monday, April 3, 2017 12:55 PM
To: FINTestimony
Cc: derrickapilado@yahoo.com
Subject: Submitted testimony for SB522 on Apr 4, 2017 14:00PM

SB522

Submitted on: 4/3/2017

Testimony for FIN on Apr 4, 2017 14:00PM in Conference Room 308

Submitted By	Organization	Testifier Position	Present at Hearing
Derrick Apilado	Individual	Support	No

Comments: I support the proposed requirement for all child care facilities to place infants to sleep on their backs, draft and adhere to safe sleep policy which meets national safety standards, have operators/staff attend annual training, and promptly report the death of any child. The American Academy of Pediatrics published literature that states about one in five sudden infant death syndrome deaths occur while an infant is in the care of someone other than a parent and that infant was sleeping in a position other than on their back. My infant niece passed away in 2015 while at a licensed day care provider. Her death could have been so very easily prevented if the operator of the day care had adhered to safe sleep practices. While the passing of this bill will never bring back my niece, it will hopefully prevent any harm coming to other infants.

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From: mailinglist@capitol.hawaii.gov
Sent: Monday, April 3, 2017 12:51 PM
To: FINTestimony
Cc: c_umipeg@yahoo.com
Subject: Submitted testimony for SB522 on Apr 4, 2017 14:00PM

SB522

Submitted on: 4/3/2017

Testimony for FIN on Apr 4, 2017 14:00PM in Conference Room 308

Submitted By	Organization	Testifier Position	Present at Hearing
Christine Umipeg-Apilado	Individual	Support	No

Comments: I support the proposed requirement for all child care facilities to place infants to sleep on their backs, draft and adhere to safe sleep policy which meets national safety standards, have operators/staff attend annual training, and promptly report the death of any child. The American Academy of Pediatrics published literature that states about one in five sudden infant death syndrome deaths occur while an infant is in the care of someone other than a parent and that infant was sleeping in a position other than on their back. My infant niece passed away in 2015 while at a licensed day care facility. Her death could have been so very easily prevented if the operator of the day care had adhered to safe sleep practices. While the passing of this bill will never bring back my niece, it will hopefully prevent any harm coming to other infants.

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From: mailinglist@capitol.hawaii.gov
Sent: Monday, April 3, 2017 11:12 AM
To: FINTestimony
Cc: misskido34@hotmail.com
Subject: Submitted testimony for SB522 on Apr 4, 2017 14:00PM

SB522

Submitted on: 4/3/2017

Testimony for FIN on Apr 4, 2017 14:00PM in Conference Room 308

Submitted By	Organization	Testifier Position	Present at Hearing
Kim Gushikuma	Individual	Support	No

Comments: I strongly support this measure which would require the Department of Human Services to post records of complaints and results of investigations relating to State licensed child care providers, as well as prepare a report to the legislature with this same detailed information each year. It is paramount to the safety of our children that parents have the ability to critically evaluate those who they entrust with their children's life. Lawmakers must be provided with accurate information about how care is being provided, and how oversight and enforcement are functioning to ensure the safety of our children and community.

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I would like to start off by introducing myself. I am the mother of Triton Forsyth who passed away while in the care of a State licensed child care provider on June 24, 2014. Although it's too late for Wiley, Triton and Zoe; I want to ensure no other family needs to go through the pain that our families suffer.

Putting infants to sleep on their back has been a known to reduce the risk of SIDS for decades now and you would think it is common sense to put a baby to sleep on their back in a crib or playpen with no pillows, stuffed animals or anything that could cause them to get caught up, suffocate or overheat.

In 2013 there was a bill that was introduced to the Hawaii State Legislature that would have required licensed day care providers to put infants under the age of one to sleep on their backs, and to take required annual training for day care providers. The Department of Human Services opposed this measure, on the grounds that the policy should be implemented through the administrative rule making process. As a result, the legislature passed a modified version of the bill which encouraged DHS to draft a safe sleep policy, but did not require it.

It has been four years and Wiley, Triton and Zoe have passed away while waiting for something to be implemented while under the care of State licensed day care providers. There may be more babies out there that have passed away, but these are the babies I am aware of.

I have two older daughters Rhiannon age 7 and Kaitlynn age 6. When we were expecting our first born I went in search of a babysitter. I work full time along with my husband and my parents worked full time jobs as well. So we were not fortunate to have our family watch our babies. It took me months to find our first sitter. She couldn't have grandchildren of her own, so she did this because she was passionate about babies and this was her way of filling that void in her life. Due to unforeseen circumstances she passed away when Kaitlynn was 2 years old. At that time I was fortunate to have the ability to send her to Preschool, rather than looking for another babysitter.

A couple years passed and we were blessed to have been pregnant with Triton. When we found out it was a boy my husband was ecstatic, as any father would be to have a son. I went in search of a new babysitter. It took months interviewing over 20 licensed caregivers and not finding any of them fitting the needs of my baby. I then came across Triton's sitter who was licensed and cared for children for over 15 years. I thought since she was licensed that meant she knew about safe sleep practices and had training on how to care for infants and toddlers, but after Triton passed away I found out that was not true. They are not trained on how to care for infants to ensure safe sleep practices or to have mandatory safe sleep classes annually. In addition there was nothing in the law that we could hold her accountable for killing our son because it was "an accident". Which in our eyes it was nothing short of neglect. It was such a shock to us that there was nothing we could do to get justice for our son. No one helps you through next steps either. We just had to research and guess what next steps to take.

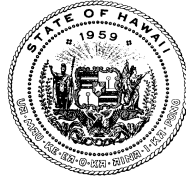
The day this all happened, it was my second day back to work and I got the call no parent ever wants to receive. I got a call from a police officer who advised me to go to Queen's Medical West regarding my son Triton. I asked what happen and he said that he would explain when I got there and to please drive safely. It was the longest drive of my life thinking what may have happened and telling myself don't think bad thoughts, it may just be a bad cut/bruise. When I got there the nurse would not tell me what

happen and at that moment I knew he was gone and something horrible happened. They took me into a private room and told me that he was found by the babysitter upstairs on a comforter folded into quarters face down and that she went to check on him an hour after putting him down and he was sleeping; then went back up an hour later to find him unresponsive with blood coming out of his nose. She then called 911 and administered CPR until Emergency Services arrived.

My two daughters were in school and my husband was on a business trip in Alaska. They called my mom and asked that she pick up my daughters and come to the hospital because it was almost the time they needed to be picked up before getting charged for picking them up late. She didn't want them to see him in the hospital and was going to stop by and then go and pick them up. She called the school and they were willing to watch the girls although it was almost past the time we were supposed to pick them up.

After seeing my son for the last time and saying our prayers, we left the hospital and my mom went to pick up the girls and I went home to get some things to sleep at her house. When they got home my older daughter came bursting through the door and said "Triton! Where are you Triton? (Looking in his playpen and running upstairs to look in his crib) Is he hiding from us? Where is he?" I sat them down to let them know that Triton was in heaven with the angels.

I fully support the proposal to require all child care facilities, for children under one year of age be required to place babies on their backs for sleeping, establishing notice and annual training requirements should have been implemented back in 2013. If this was put into place back then there is a possibility that Wiley, Triton and Zoe would still be here with us today. Although it is too late for our babies, making a safe sleep policy which is in line with federal guidelines into State law will prevent the needless deaths of any other precious baby. If we do not put this law into place precious babies will continue to be at risk.



STATE OF HAWAII
DEPARTMENT OF HEALTH
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LATE

**Testimony COMMENTING on S.B.522 S.D.1, H.D. 1
RELATING TO HUMAN SERVICES
REPRESENTATIVE SYLVIA LUKE, CHAIR
COMMITTEE ON FINANCE**

Hearing Date: April 4, 2017

Room Number: 308

1 **Fiscal Implications:** None to the Department of Health. The Department defers to the
2 Department of Human Services on fiscal implications of S.B 522, S.D. 1, H.D. 1.

3 **Department Testimony:** The Department of Health (DOH) appreciates the intent of this bill
4 and offers comments.

5 The Centers for Disease Control and Prevention (CDC) reports there were 3,700 sudden
6 unexpected infant deaths in the United States in 2015. These deaths occurred among infants less
7 than one year old and had no immediate obvious cause. The three most common reported causes
8 of unexpected infant deaths are: Sudden Infant Death Syndrome, unknown cause, and accidental
9 suffocation and strangulation in bed. The CDC identified several actions that parents and
10 caregivers can take to reduce the risk of Sudden Infant Death Syndrome and Sudden Unexpected
11 Infant Death. These include placing babies on their back when putting them to sleep, using a firm
12 mattress with a fitted sheet, keeping soft objects out of the baby's sleep area, sharing your room
13 but not sharing your bed with your baby, and not smoking during pregnancy or around the baby.

14 In Hawaii, the DOH, Family Health Services Division reviews hospital policies related to safe
15 sleep education for parents. Also, the DOH promotes the American Academy of Pediatrics
16 guidelines of safe sleep when providing home visits with families. The DOH participates as a
17 member of Safe Sleep Hawaii which provides statewide leadership in preventing infant deaths
18 through educating parents, caregivers, teachers and health care providers on safe sleep practices
19 following the American Academy of Pediatrics guidelines. The Safe Sleep partnership includes:
20 State of Hawaii, Department of Health, Department of Human Services, Department of

1 Education, Keiki Injury Prevention Coalition, Kapiolani Medical Center for Women and
2 Children, Consumer Product Safety Commission, and other agencies and advocates.

3 As members of Safe Sleep Hawaii, the Department of Health and the Department of
4 Human Services partner to combine resources and promote safe sleep education and practices to
5 reduce and/or eliminate preventable infant injuries and premature death. In February 2017, DOH
6 and DHS attended the National Institute for Children’s Health Quality (NICHQ) Infant Mortality
7 Collaborative Improvement & Innovation Networks (CoIIN) conference. The purpose of this
8 national meeting was to develop strategies for strengthening existing, and building new,
9 partnerships to accelerate improvement and to facilitate state progress on actions to reduce infant
10 mortality.

11 Other accomplishments of Safe Sleep Hawaii include: 1) The Parent Line, a DOH
12 contracted statewide confidential telephone line for information and referral on child behavior,
13 child development, parenting, caregiver support, and community resources; and 2) Distribution
14 of cardboard bassinets to parents of newborns. The cardboard bassinets have been handed out to
15 new parents for decades in Finland, which has one of the lowest infant mortality rates in the
16 world. Kapiolani Medical Center for Women and Children is participating in a pilot project that
17 will provide safe sleep education and cardboard bassinet boxes that encourage safe sleeping for
18 babies to parents and caregivers.

19 The Department’s Strategic Plan 2015-2018, identified one of its priorities to address
20 conditions contributing to child deaths. The DOH Child Death Review conducts comprehensive
21 and multidisciplinary reviews of children from 0-18 years to understand risk factors. The reviews
22 focus on prevention and provides recommendations to prevent future deaths to keep children safe
23 and healthy. The Child Death Review group completed multidisciplinary reviews of Sudden
24 Infant Death Syndrome and Sudden Unexpected Infant Death cases from August 2016 through
25 December 2016. On March 1, 2017, safe sleep recommendations resulting from the reviews was
26 presented to the Child Death Review Council, a group that is responsible for identifying agencies
27 that will develop action plans for implementation. Follow up actions include: a start time for the

1 distribution of the baby boxes bassinets at Kapiolani Medical Center within a two week period
2 for all families that are interested in participating in the safe sleep training and trying the
3 bassinets. Hawaii Island arranged for a community presentation—including first responders
4 (police and fire departments) and DOH staff—to provide information about safe sleep practices.
5 Additionally, for Hawaii Island, training on child death review data collection methods will be
6 scheduled to ensure proper tracking of the facts presented during the reviews.

7 We acknowledge the important efforts of the Department of Human Services and look
8 forward to continue working together on promoting safe sleep practices and fostering healthy
9 children and families.

10 Thank you for this opportunity to testify.



From: mailinglist@capitol.hawaii.gov
Sent: Monday, April 3, 2017 7:19 PM
To: FINTestimony
Cc: dkg1031@gmail.com
Subject: *Submitted testimony for SB522 on Apr 4, 2017 14:00PM*

SB522

Submitted on: 4/3/2017

Testimony for FIN on Apr 4, 2017 14:00PM in Conference Room 308

Submitted By	Organization	Testifier Position	Present at Hearing
Debra Koonohiokala Norenberg	Individual	Support	No

Comments:

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LATE

April 3, 2017

To: Representative Sylvia Luke, Chair
Representative Ty J.K. Cullen, Vice Chair
Committee on Finance

From: Deborah Zysman, Executive Director
Hawaii Children's Action Network

Re: SB 522 SD 1 HD 1 – Relating to Human Services
Hawaii State Capitol, Room 308, April 4, 2017, 2:00 PM

On behalf of Hawaii Children's Action Network (HCAN), we are writing to support the intent of SB 522 SD 1 HD 1– Relating to Human Services

HCAN believes that providing a safe environment for children to sleep in while in a childcare setting is vital. HCAN has been working with the Department of Human Services (DHS) to update their administrative rules to address this issue. These new rules were just adopted in February.

SB 522 SD 1 HD 1 addresses the Safe Sleep policies for children under age one, yet does not address children over age one. This bill should be expanded to better match the administrative rules adopted by DHS.

In addition to the administrative rules and this bill, there should be a companion community education program to help educate families in addition to the child care workers on safe sleep practices for children.

For these reasons, HCAN respectfully requests that the committee add the safe sleep requirements for children over age one to be consistent with the Department of Human Services.

HCAN is committed to building a unified voice advocating for Hawaii's children by improving their safety, health, and education. Last fall, HCAN convened input in person and online from more than 50 organizations and individuals that came forward to support or express interest for a number of issues affecting children and families in our state that resulted in the compilation of 2017 Hawaii Children's Policy Agenda, which can be accessed at <http://www.hawaii-can.org/2017policyagenda>.