

BEFORE THE
DEPARTMENT OF SOCIAL SERVICES
STATE OF CALIFORNIA

In the Matter of the Accusation)
Against:)
)
 YUK WAN CHIN) Case No. 7497258001
 1415 Silliman Street)
 San Francisco, CA 94134) OAH No. N 1997090419
)
) 99 CDSS 05
)
_____)

PROPOSED DECISION

This matter was heard before Jonathan Lew, Administrative Law Judge, State of California, Office of Administrative Hearings on October 10, 1997, in Oakland, California.

Complainant was represented by Kay L. Deli, Senior Staff Attorney, Legal Division, Department of Social Services.

Peter Chao, Esq. of Chao & Tuann, 807 Montgomery Street, San Francisco, California 94133, made a special appearance on behalf of Yuk Wan Chin.

Submission of the matter was deferred upon receipt of further evidence and closing briefs. Respondent's Points and Authorities in Opposition was received on October 20, 1997, and marked as Exhibit A for identification. Complainant's Brief in Support of Department's Jurisdiction was received on October 21, 1997, and marked as Exhibit 8 for identification. A Medical Examiner/Investigator's report was received on October 27, 1997, and marked and received into evidence as Exhibit 9. The matter was thereafter submitted.

FINDINGS OF FACT

I

Procedural History - Complainant Dennis Walker, Chief of the Central Operations Branch, filed the Accusation on September 23, 1997. He issued the Accusation pursuant to the

authority delegated to him by Eloise Anderson, Director of the California Department of Social Services (Department). Yuk Wan Chin (respondent) filed a Notice of Defense and request for hearing on September 24, 1997. A Notice of Hearing dated September 26, 1997, was thereafter served on respondent.

On October 6, 1997, Peter Chao, counsel for respondent, requested a continuance on the basis that he had just been retained on October 1, and that he did not have enough time to adequately prepare a defense. After discussion with Department counsel, the request for a continuance was denied, except that respondent was given opportunity to continue to a later date the presentation of her defense.

On October 9, 1997, respondent gave notice that she was withdrawing her Notice of Defense. On October 10, counsel for respondent made a special appearance for purposes of objecting to the Department's jurisdiction to proceed given respondent's withdrawal of her Notice of Defense. The parties were given an opportunity to brief this issue. The hearing then proceeded by way of default under Government Code section 11520.

II

The Department is the agency of the State of California responsible for the licensure of family day care homes pursuant to the California Child Day Care Facilities Act. (Health and Safety Code section 1596.70 et seq.).

III

Respondent is licensed by the Department to operate a family day care home located at 1415 Silliman Street, San Francisco, California. She was initially licensed on September 16, 1991. The facility has a total capacity of six, with no more than three or four infants.¹

Complainant seeks revocation of respondent's family day care license, alleging that she is not in compliance with or has violated applicable licensing statutes and regulations, and that she has engaged in conduct inimical to the health, morals, welfare and safety of children in care. The allega-

¹ Infant means a child under age two. If only infants are in care, the license provides for a maximum of four. And if there are older children, respondent is allowed to have up to three infants and three older children. Under new law, licensees may now also have two additional school age children in care. Were there also school age children in respondent's facility, she could have up to eight children; that is to say, two school age, four pre-schoolers and two infants.

tions turn largely on circumstances surrounding the death of a child in care.

IV

Child #1 (DOB 4/10/96) had been in respondent's care since June 1996. Around 4:00 p.m. on September 8, 1997, respondent called the mother of Child #1 and asked her to come, and that it was an emergency. Respondent speaks Cantonese, and little English. The mother does not speak Cantonese. Nothing was communicated to her about the nature of the emergency. The mother immediately contacted her husband who was at home, six blocks from the facility, and asked him to go over to the facility and pick up their son. He arrived at the facility perhaps three minutes later.

Upon arrival, the father observed his son being cradled in the arms of respondent's husband. Mr. Chin told the father that the child had been walking, and had then passed out and fallen down. Saliva and blood were coming out of Child #1's mouth. The father shouted for them to call 911. Mr. Chin then asked respondent to make the call and she did. The 911 call was made two to three minutes after the father's arrival. No call to 911 or for other emergency assistance had been made prior to this call.

V

When the father arrived, the child's face was very cold and his lips blue. He was not breathing. The father called 911 a second time and requested instruction on how to do child cardiopulmonary resuscitation. The father proceeded to do CPR but every time he blew air into the child, blood and regurgitation returned. The fire department arrived, and then paramedics. They assumed emergency care and continued resuscitation efforts.

The paramedics had been dispatched at 4:16 p.m. and arrived at the facility at 4:22 p.m. The child was found to be very pale, cyanotic, with blue around his lips. There was no heart beat. They decided to intubate the child and found vomit in his airway. Paramedic Katherine True was able to visualize a whole grape way in back of the child's trachea, and she then proceeded to remove the grape from the airway using a McGill forceps. Within thirty seconds his color returned to normal, and they continued efforts to restore cardiac function. The child was administered epinephrine and atropine but heart activity did not return. He was transported to San Francisco General Hospital where they continued heroic efforts until he was pronounced dead at 5:20 p.m.

VI

Assistant Medical Examiner Michael J. Ferenc, M.D. attributes cause of death to Asphyxia due to foreign obstruction of airway. (Exhibit 9)

There was a bowl of grapes atop a table, four feet off the ground in the facility. It was out of reach of Child #1. The origin of the grape that lodged in his airway is not known. That is to say, it was not determined whether the child regurgitated a grape that he had earlier been given during lunch, or whether he later swallowed a grape that he found around the facility.

Mr. Chin reported to Department licensing program analyst Leslie Gomba that the child had been given some grapes for lunch, but that the grapes had been cut in half. He also stated that the child had been given half a bottle of apple juice and was put down for a nap. Between 3:30 and 4:00 p.m. Mr. Chin noticed spit up on the bedding and then picked up the child. He reported that the child then vomited on his shoulder, and then stopped breathing. He then patted the child on the back to start breathing, and avers that at this point his wife (respondent) called 911.

Respondent reported to licensing that the child was sickly, and had a history of seizures, particularly following a fit or tantrum. She stated that she would have to pat his back to get him to start breathing again after such episodes. This is disputed by the child's mother. The medical examiner's report (Exhibit 9) notes that the child had a history of asthma requiring the use of Albuterol on occasion, and the child reportedly "would hold his breath when he was very upset and crying."

VII

There is no evidence that 911 had been called by respondent prior to the arrival of Child #1's father. She called 911 only at the father's urging. Respondent's failure to earlier assess the critical nature of Child #1's condition, and her failure to immediately call 911 resulted in a delay in emergency medical response to the facility.

It was also established that respondent herself administered no emergency treatment or care to the child. When asked why she had not administered CPR, respondent indicated to Ms. Gomba that she was too excited and panicky at the time.

VIII

Respondent had received child/infant CPR training, but her certification for same had expired. She believed that she was only required to take CPR training one time. Department licensing supervisor Minnie Lau advised respondent that updated CPR training was needed and asked her to contact a Chinatown class immediately for training, and in the alternative to take a class elsewhere with an interpreter.

It was established that on September 4, 1997, respondent did not have the current required preventative health practice training, including pediatric cardiopulmonary resuscitation and pediatric first aid.

IX

A triennial facility visit and investigation into the child's death was conducted by Department staff on September 8, 1997. On that date the following deficiencies were present in the facility:

1. Furniture polish, rubbing alcohol, spray cleaner and Hexol were stored in an unlocked bathroom cabinet. There was no safety latch on the cabinet. Respondent immediately removed the cleaning compounds and other items brought to her attention.

2. There were six children in care, four of whom were infants. Respondent was allowed to have up to four infants in care, but only if there were no other children present. (See footnote 1.)

3. A children's records review was conducted. Certain children's records were not available for the Department to review. Respondent failed to provide documentation and forms for parents' rights receipt, consent for emergency medical treatment and personal rights for all children in care. She also could not produce admission agreements for six children in care.

DETERMINATION OF ISSUES

I

By special appearance, respondent requested and was granted leave to brief the issue of Department jurisdiction. Instead, she submits argument that the proceedings should have been continued. Having withdrawn her notice of defense on October 9, the matter of whether the continuance should have

been granted is moot. Respondent's remedy after denial of application for continuance is to seek appropriate judicial relief in the superior court under Government Code section 11524(c). She did not do so.

Respondent was given an opportunity to continue and to present her defense at a later date. Contrary to her argument otherwise, such lapse of time would, if anything, have allowed the "highly emotional tone" of the proceedings to have attenuated. Granting respondent a continuance to more thoroughly prepare her defense under these circumstances did not violate her due process rights.

II

Complainant correctly argues that the Department has jurisdiction to proceed with disciplinary action, even after a respondent withdraws her notice of defense. Under Health and Safety Code section 1596.854 the Department may institute or continue a disciplinary proceeding against a license following the suspension, expiration, or forfeiture of the license. Respondent's license was suspended on September 23, 1997.

Section 1596.854 permits disciplinary action even if a respondent did not submit a notice of defense. This result allows the Department to create a record to guard against loss or stagnation of evidence, and in anticipation of future re-application for Department licensure. A respondent could otherwise reapply for a license when such evidence is no longer available to the Department.

Government Code section 11520(a) allows the Department to take action even if the respondent fails to file a notice of defense, and allows an agency to take action based upon evidence including respondent's express admissions or affidavits. Title 1 California Code of Regulations (CCR) section 1014(c) further provides that if a party withdraws a notice of defense or request for hearing, the agency shall decide whether to proceed with the hearing as a default. That was done in this case.

III

Findings IV through VII - Cause exists for revocation of respondent's license to operate a family day care home under Health and Safety Code section 1596.885. Respondent failed to contact emergency medical personnel and to provide emergency care when a child in care stopped breathing. (Title 22 CCR section 102423(a)(2))

IV

Finding VIII - Cause for disciplinary action exists under Health and Safety Code sections 1596.885 and 1596.866. Respondent failed to have the required preventative health practice training.

V

Finding IX - Cause for disciplinary action exists under Health and Safety Code section 1596.885, and Title 22 CCR sections 102417, 102416.5 and 102421.

ORDER

Respondent Yuk Wan Chin's license to operate a family day care home for children, located at 1415 Silliman Street, San Francisco, California is revoked.