

2.

The Center provides transportation services as part of its daily operations as a Child Care Learning Center. Its drivers routinely transport children to local schools in the morning and return them to the Center in the afternoon. (Respondent's Exhibit 1; Order Affirming Emergency Closure).

Transportation Rules Governing Child Care Learning Centers

3.

DECAL's regulations require that child care learning centers keep a passenger checklist inside each vehicle during transportation. The driver or another designated staff member is required to immediately document when a child enters or exits the vehicle by placing a check mark or other symbol next to that child's name. The purpose of this rule is to maintain an adequate accounting of the whereabouts of the children under the center's care. (GA. COMP. R. & REGS. 591-1-1-.36(7)(c)2.).

4.

After all children have been unloaded, the driver or another staff member who was on the vehicle during transportation must conduct a physical investigation of the vehicle by walking through it and checking under the seats and in all recesses to ensure that no child remains on the vehicle. Upon completing this inspection, the driver or designated staff member must sign the passenger checklist to confirm that every child has exited the vehicle. (GA. COMP. R. & REGS. 591-1-1-.36(d)1.).

referenced therein. (*Perkins d/b/a Charlotte's Webb Learning Center v. Ga. Dep't of Early Care and Learning*, Docket No. OSAH-DECAL-CCLC-1448445-11-Teate, (April 24, 2014) (hereinafter "Order Affirming Emergency Closure"))).

5.

For vehicles that are not equipped with an alarm, a second staff member who was not on the vehicle during transportation must conduct a second walkthrough of the vehicle to ensure that all children have been unloaded. The second staff member must also sign the passenger checklist after they have conducted the second check and ascertained that all children have exited the vehicle. GA. COMP. R. & REGS. 591-1-1-.36(d)2.).

April 14, 2014 Incident

6.

During afternoon transportation on April 14, 2014, one of the Center's vehicles, a passenger van, picked up children from a local elementary school and returned them to the Center at approximately 4:24 p.m. One of the passengers returning to the Center from school was K.B., a five-year-old child. After unloading what she thought was all of the vehicle's passengers, the driver exited the vehicle and left it parked in the Center's parking lot. Unbeknownst to the driver, K.B. remained on board the vehicle. Although K.B. did not exit the vehicle with the other children, the driver indicated that K.B. had been dropped off at the Center by placing a check mark next to his name on the passenger checklist. (Respondent Exhibit 1; Order Affirming Emergency Closure).

7.

The driver exited the vehicle at the conclusion of the afternoon transportation route without first conducting an adequate "walkthrough" as required by DECAL's transportation rules. Moreover, the staff member designated by the Center to conduct second checks of passenger vehicles did not perform the requisite second physical walkthrough, but had instead briefly stepped inside the vehicle and glanced under the seats from the doorway. Although neither the vehicle's driver nor the second staff member properly conducted the required

physical walkthroughs, both staff members signed the passenger checklists, indicating the walkthroughs had been performed. (Testimony of Ashley Wilson; Respondent Exhibits 1, 7).

8.

As a result of the staff members' failure to adhere to transportation rules, K.B. was left in the parked vehicle after all other passengers had exited and transportation had concluded for the day. K.B. remained on board the vehicle in the Center's parking lot for more than four hours. (Testimony of Ashley Wilson, Gloria Dumas; Respondent Exhibit 4, 5, 9).

9.

The Center's staff members did not discover that a child had been left in the vehicle until approximately 8:42 p.m., when K.B. exited the vehicle and walked across the parking lot to the Center and knocked on the door. Gloria Dumas, a teacher at the Center, answered the door and let K.B. inside. Dumas initially thought K.B. had been dropped off by his mother, but eventually determined that K.B. had been left on the Center's vehicle after afternoon transportation. Dumas called Perkins and informed her of the situation. Perkins then returned to the Center. (Testimony of Gloria Dumas, Charlotte Perkins; Respondent Exhibits 4, 5, 6, 8, 9).

10.

As K.B. did not appear to them to be distressed or to have suffered any visible adverse effects from his prolonged stay in the vehicle, staff members did not seek medical attention for him. When K.B.'s mother arrived as scheduled to pick up K.B. and his siblings from the Center shortly before 9:00 p.m., Perkins represented to her that K.B. had been left on the Center's vehicle for approximately five minutes. (Testimony of Gloria Dumas, Charlotte Perkins; Respondent Exhibit 9).

11.

Later that evening, after K.B. told his mother that he had been left on the bus for hours

and complained of abdominal pain, K.B.'s mother took him to the emergency room. Although K.B. suffered emotional distress as a result of the incident, he displayed no signs of physical injury and was released from the hospital. (Order Affirming Emergency Closure).

April 15, 2014 Complaint Investigation

12.

On Tuesday, April 15, 2014, DECAL received a complaint that a five-year-old child had been left unattended on a vehicle at the Center. DECAL immediately dispatched Ashley Wilson ("Consultant"), a Childcare Consultant with DECAL's Complaint Unit, who arrived at the Center at approximately 2:30 p.m. (Testimony of Ashley Wilson).

13.

Upon arriving at the Center, the Consultant was met by Perkins, who acknowledged that a child had been left unattended on one of the Center's vehicles. Perkins reported to the Consultant that she retrieved the child from the vehicle at approximately 5:05 p.m. on April 14, 2014. According to Perkins, K.B. had been left unattended on the vehicle for approximately five minutes. (Testimony of Ashley Wilson; Respondent Exhibit 9).

14.

The Consultant commenced a review of the Center's transportation records for the relevant date, whereupon she discovered that the Center's van had arrived at the Center at approximately 4:24 p.m. on April 14. After the Consultant told Perkins of her findings, Perkins revised her statement, claiming that the child had been left on board the vehicle for approximately forty minutes. (Testimony of Ashley Wilson; Respondent Exhibits 1, 9).

15.

After concluding her review of the transportation records, the Consultant asked Perkins if the Center maintained video surveillance records. Perkins told the Consultant that the Center did

maintain such records and led the Consultant to the office where they were kept. Upon reaching the office, however, the Consultant was told that the Center's recording equipment and the requested surveillance records were missing due to theft.² (Testimony of Ashley Wilson; Respondent Exhibit 9).

16.

The Consultant next interviewed Gloria Dumas, who reported that K.B. had walked to the Center from the parking lot while the class was watching a movie. Dumas's responses were evasive during the interview, and she would not provide an estimate of what time K.B. had entered the Center. However, the Consultant was able to estimate that K.B. returned to the Center at approximately 8:30 p.m. by looking at the schedule of activities for K.B.'s class, which indicated that the class watched a movie between 8:30 p.m. and 9:00 p.m. (Testimony of Ashley Wilson; Respondent Exhibit 3, 8, 9).

17.

Noting the discrepancies in the director's and teacher's accounts of the incident, the Consultant again interviewed Perkins. During this interview, Ms. Perkins admitted that she had not retrieved K.B. from the Center's vehicle at 5:05 p.m. as she originally reported. Perkins admitted to the Consultant that K.B. had been left on the vehicle for approximately four hours. (Testimony of Ashley Wilson; Respondent Exhibit 9).

18.

During the April 15, 2014 site visit, the Consultant also observed rule violations at the Center that were unrelated to the incident involving K.B. After the Consultant determined that a

² Perkins produced the video evidence at the preliminary hearing on the emergency closure of the Center with the explanation that, at the time of the April 15 site visit, the recordings had been placed into storage. (Order Affirming Emergency Closure). The video surveillance footage was submitted into the record by Respondent at the August 13 hearing of the present matter. (Respondent Exhibits 4, 5).

four-year-old child had been placed in the one- and two-year-old classroom as a form of punishment, she cited the Center for violation of Rule 591-1-1-11(2)(d), which prohibits “verbally abusing or humiliating a child. . . .” The Consultant also cited the Center for violating Rule 519-1-1-32(6), which requires that children be supervised at all times, after she observed a staff member briefly leave a classroom and walk into the Center’s infant class room on two separate occasions “leaving the one, two, three and four-year-old children in care without staff supervision.” Finally, the Consultant issued a citation for violation of Rule 591-1-1-19(1), which requires that Child Care Learning Centers provide thirty-five square feet of usable space per child, after she observed ten children in a classroom licensed for only eight. (Testimony of Ashley Wilson; Respondent Exhibit 9).

Emergency Closure of Charlotte’s Webb

19.

After concluding her investigation at the Center, the Consultant reported her findings to her supervisor, April Rogers, Director of DECAL’s Complaint Unit. Shortly thereafter, DECAL’s regulatory and legal staff conducted a “staffing” to review all available data regarding the incident and the Center. Based on this review, DECAL determined that the Center’s failure to follow transportation rules and regulations placed the children entrusted to the Center’s care in imminent danger and commenced emergency closure proceedings pursuant to O.C.G.A. § 20-1A-13. (Testimony of April Rogers).

20.

On April 17, 2014, DECAL issued an Order for Intended Emergency Closure. Perkins filed a timely Request for a Preliminary Hearing on April 18, 2014. On April 22, 2014, a preliminary hearing on DECAL’s intended emergency closure of the Center was held before the Honorable Judge Steven W. Teate. Concluding that the children at the Center were in imminent

danger within the meaning of O.C.G.A. § 20-1A-13(c)(1)(B), Judge Teate affirmed the emergency closure in a Final Decision issued on April 24, 2014. The Center was thereafter closed for a period of twenty-one days pursuant to O.C.G.A. § 20-1A-13(c)(1). (Testimony of April Rogers; *Perkins d/b/a Charlotte's Webb Learning Center v. Ga. Dep't of Early Care and Learning*, Docket No. OSAH-DECAL-CCLC-1448445-11-Teate (April 24, 2014)).

Additional Transportation Violations at Charlotte's Webb

21.

Following the April 22, 2014 preliminary hearing, the Center remained open pending the April 24 issuance of the Final Decision on the Emergency Closure (“the Monitoring Period”), during which time DECAL dispatched monitors, including Wilson, to remain on site and observe conditions at the Center. Monitors observed further transportation rule violations at the Center during the Monitoring Period. Specifically, during transportation on April 23, 2014, monitors observed that a staff member improperly secured children on a passenger vehicle by “double-buckling,” or using a single safety belt to secure two children to a seat designed for one passenger.³ Monitors also observed that nine children were being transported on the vehicle, a Chrysler Town & Country minivan, which has a total seating capacity of seven individuals.⁴ (Testimony of Ashley Wilson).

³ Monitors cited this as a violation of Ga. Comp. R. & Regs. 591-1-1-.36(4)(f)1, which provides that “[a]ll children transported in a vehicle provided by or used by the center shall be secured in a child passenger restraining system or seat safety belt in accordance with current state and federal laws and regulations.” (Notice of Revocation dated May 14, 2014; GA. COMP. R. & REGS. 591-1-1-.36(4)(f)1).

⁴ Monitors cited this as a violation of Ga. Comp. R. & Regs. 591-1-1-.36(4)(f)2, which provides that “[n]o vehicle used by the center to transport children shall exceed the manufacturer’s rated seating capacity for the vehicle. . . .” (Notice of Revocation dated May 14, 2014; GA. COMP. R. & REGS. 591-1-1-.36(4)(f)2).

Respondent's Action to Revoke Charlotte's Webb's License

22.

DECAL's regulatory and legal staff conducted a second staffing during the Emergency Closure period. After considering the egregiousness of the incident, the lack of cooperation and candor exhibited by Perkins and other Center staff members during the investigation, the rule violations observed at the Center during the April 15 site visit, the transportation violations observed at the Center during the Monitoring Period, and other mitigating and aggravating factors,⁵ DECAL decided to revoke the Center's license. (Testimony of April Rogers).

23.

In a letter dated May 14, 2014, DECAL notified Perkins that it intended to revoke the Center's license. On or about May 20, 2014, Perkins requested a hearing and the matter was referred to OSAH for adjudication. (Notice of Revocation dated May 14, 2014; Request for Hearing dated May 19, 2014).

24.

The Center did not dispute the facts of the April 14, 2014 incident or DECAL's subsequent investigation at the hearing on this matter. Rather, the Center introduced evidence intended to demonstrate that revocation of its license was unwarranted considering the Center's positive history of operations and the value of the services that it provides to the community. The Center, through counsel, suggested continued placement of DECAL monitors at its facility as an alternative to revocation of the Center's license. (Testimony of Charlotte Perkins, Gloria Dumas).

⁵ Rogers testified that DECAL ordinarily considers such mitigating factors as: the Center's history of compliance; the Center's cooperation during an investigation; whether the Center self-reports; and whether the center takes immediate remedial action in the wake of an incident. In the present case, DECAL did not find sufficient mitigating factors to warrant a lesser sanction. (Testimony of April Rogers).

III. CONCLUSIONS OF LAW

1.

DECAL bears the burden of proof in this matter. GA. COMP. R. & REGS. 616-1-2-.07.

The standard of proof is a preponderance of evidence. GA. COMP. R. & REGS. 616-1-2-.21.

2.

Georgia law provides that DECAL has the authority to exercise disciplinary action against a Child Care Learning Center licensee upon a finding that the licensee has:

- (1) Knowingly made any false statement of material information in connection with the application for a license, or in statements made or on documents submitted to the department as part of an inspection, survey, or investigation, or in the alteration or falsification of records maintained by the early care and education program;
- (2) Failed or refused to provide [DECAL] with access to the premises subject to regulation or information pertinent to the initial or continued licensing of the program;
- (3) Failed to comply with the licensing requirements of this state;
- (4) Failed to pay the annual fee for licensure, registration, or commission of early care and education programs; or
- (5) Failed to comply with any provisions of this Code section.

O.C.G.A. § 20-1A-12(b) (2014). Such disciplinary action may include suspension, restriction, or revocation of a license to operate a Child Care Learning Center. O.C.G.A. 20-1A-12(c) (2014).

In the present case, DECAL asserts that the Center's license should be revoked inasmuch as it committed serious rule violations, and has thereby failed to comply with state licensing requirements. DECAL further asserts that revocation of the Center's license is warranted because Perkins and other staff members "knowingly made . . . false statement[s] of material information" in connection with the investigation of the April 14, 2014 incident.

DECAL proved by a preponderance of the evidence that the Center committed serious rule violations and that disciplinary action is warranted. The Court concludes that the Center committed the following violations of the rules and regulations governing Child Care Learning Centers:

- (1) The Center failed to ensure that a child was not left unattended on a vehicle in violation of Ga. Comp. R. & Regs. 591-1-1-.36(10);
- (2) The Center failed to document in writing with a check mark or other mark/symbol on the passenger checklist each time a child enters and exits the Center's vehicle in violation of Ga. Comp. R. & Regs. 591-1-1-.36(7)(c)2;
- (3) The Center failed to ensure that a thorough vehicle check of the vehicle by the driver occurred after children were unloaded from the vehicle in violation of Ga. Comp. R. & Regs. 591-1-1-.36(6)(d)1
- (4) The Center failed to ensure that a thorough check of the vehicle was conducted by a second designated staff member in violation of Ga. Comp. R. & Regs. 591-1-1-.36(7)(d)2;
- (5) The Center failed to ensure that all children were properly supervised at all times in violation of Ga. Comp. R. & Regs. 591-1-1-.32(6);
- (6) The Center failed to ensure that children were kept clean, dry, and comfortable in violation of Ga. Comp. R. & Regs. 591-1-1-.17(2);
- (7) The Center failed to immediately notify parents when a child experienced symptoms of moderate discomfort in violation of Ga. Comp. R. & Regs. 591-1-1-.07(2);
- (8) The Center failed to cooperate with a Department investigation in violation of Ga. Comp. R. & Regs. 591-1-1-.37(c).
- (9) The Center failed to ensure that vehicles used to transport children did not exceed the vehicle's seating capacity, in violation of Ga. Comp. R. & Regs. 591-1-1-.36(2)(f)2;
- (10) The Center failed to ensure that children were properly restrained with seat belts, in violation of Ga. Comp. R. & Regs. 591-1-1-.36(2)(f)1.

4.

DECAL further established that revocation of the Center's license is the appropriate penalty. In considering the appropriateness of revocation, as opposed to a lesser sanction, the Court has taken into account the following factors:

- (1) The serious and potentially fatal consequences to a child if the incident that occurred on April 14, 2014 is repeated;
- (2) The Center's seriously deficient response in the wake of the April 14, 2014 incident;
- (3) The Center's failure to report the April 14, 2014 incident to DECAL;
- (4) The Center's continued inability to comply with rules governing Child Care Learning Centers, as evidenced by the transportation rule violations observed at the Center on April 23, 2014; and
- (5) The evasiveness, dishonesty, and lack of candor exhibited by Perkins and other staff members during DECAL's investigation into the April 14, 2014 incident, which strongly indicates that alternative sanctions, such as monitoring, would be ineffective.


5.

The Court does not doubt that the Center provided a valuable service to the community or that it was founded and operated by Perkins with the best of intentions. However, the above-described violations establish that the Center's continued operation poses an unacceptable risk to the safety of children and, thus, that revocation of its license is appropriate.

IV. DECISION

In accordance with the foregoing Findings of Fact and Conclusions of Law, DECAL's revocation of the Center's license is hereby **AFFIRMED**.

SO ORDERED, this 4th day of September, 2014.



KIMBERLY W. SCHROER
Administrative Law Judge