BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

HOPE FOR KIDS ACADEMY, LLC,	:	
	:	
Petitioner,	:	
	:	**Docket No.**
v.	:	**OSAH-DECAL-CCLC-1407273-31-**
	:	**KENNEDY**
GEORGIA DEPARTMENT OF EARLY CARE AND LEARNING,	:	
	:	
Respondent.	:	

FINAL DECISION
ORDER AFFIRMING EMERGENCY CLOSURE

I. INTRODUCTION

This matter is an appeal by Petitioner, Hope For Kids Academy, LLC, of the Order for Intended Emergency Closure of its child care facility issued by the Commissioner for the Georgia Department of Early Care and Learning ("Department") on August 26, 2013. A preliminary hearing pursuant to O.C.G.A. § 20-1A-13 was held on August 30, 2013, before the undersigned Administrative Law Judge of the Office of State Administrative Hearings.

Petitioner was represented by Albert Mitchell, Esq. The Department was represented by Kimberly Alexander, Esq. After careful consideration of the evidence and the arguments of the parties, and for the reasons set forth below, the Order for Intended Emergency Closure is hereby **AFFIRMED**.

II. FINDINGS OF FACT

1.

Hope for Kids Academy, LLC (hereinafter "Center" or "facility") is a child care learning center located in Forest Park, Georgia. It was first licensed in July 2011. (Testimony of Shenetta McNair, Complaint Unit Lead Consultant; Exhibit R-2)

2.

The facility, which is owned and operated by Ulo Obadiaru, offers day care services for children ages 6 weeks to school age. The Center also provides before and after school care for school age children up to 12 years old. The Center is authorized to provide transportation services for children who attend its programs. (Testimony of Tahishe Smith, Complaint Unit Consultant; Testimony of McNair; Exhibits R-2, R-5)

3.

The Center typically transports children to and from two local elementary schools, Huie Elementary and Edmons Elementary. The Center also picks up children from their homes in the morning and transports them to the elementary schools. Additionally, the facility's driver uses the Center's van to pick up various employees from their homes and bring them to the Center. (Testimony of Melody Lea; Exhibits R-3, R-4)

4.

One of the Center's former employees, Melody Lea, had her five children enrolled at the Center.[1] Her youngest child, age 4, was enrolled for full-day services. Her four other children, ages 6, 7, 8 and 9, attended the facility both before and after school. (Testimony of Lea)

5.

On August 22, 2013, Ms. Lea arrived at the Center with her five children at 6:30 a.m. Later, her school aged children rode the facility van to their elementary school. According to the facility's Transportation Log, the four children were loaded onto the Center's vehicle at 6:59 a.m. to be transported to school. The youngest child, who attends full day care, had an eye

[1] Ms. Lea was terminated from her position as Assistant Director on August 27, 2013. The reason for the termination is not specifically known. However, Ms. Lea was scheduled to work on Monday, August 26, 2013. That day, she called to say she was running late and would come in later in the day. Ms. Lea never appeared for work. She had done this 2 to 3 times before. On Tuesday, August 27, Ms. Lea was notified that her services were not longer needed. (Testimony of Lea)

doctor appointment that Ms. Lea subsequently took her to. (Testimony of A.M., a minor child; Testimony of Lea; Exhibit R-3)

6.

When the van arrived at the Edmons Elementary School at 7:25 a.m., a school official assisted the children in exiting the van while another school official advised Joel Ikuadi, the driver, and Rickia Vann, his co-worker who had ridden with him, that they would need to start parking in a different area to drop off the children. Inasmuch as they were distracted, neither the driver nor his co-worker realized that Ms. Lea's 7-year-old daughter, A.M., did not exit the van because she had fallen asleep on the last row of seats.[2] Nevertheless, the transportation log was completed to show that all children were unloaded at the school. (Testimony of A.M.; Testimony of Lea; Testimony of Kerri Bostick; Testimony of Joel Ikuadi, the Center's driver; Exhibit R-3)

7.

When the van returned to the Center at 7:40 a.m., Ms. Vann exited the vehicle and peered into the van's windows. She did not physically check each row of seats or under the seats as is required by Respondent's rules and regulations. The driver did not complete a check of the vehicle at all. Additionally, no other staff member completed a second check of the vehicle as required by Respondent's rules and regulations. (Testimony of Smith; Testimony of McNair; Exhibits R-1, R-3)

8.

At one point, the driver exited the vehicle briefly, then returned and sat in the vehicle for approximately 30 minutes listening to music, unaware that Ms. Lea's daughter was asleep in the

[2] Typically, A.M.'s brothers enter the van before she does. The three of them sit in the last row of seats. On this day, A.M. recalled that her brothers moved to the front of the van prior to arriving at the elementary school. It is unclear whether her two brothers, ages 8 and 9, realized that their sister did not exit the vehicle.

rear of the van. (Testimony of Smith; Testimony of Ikuadi; Testimony of McNair)

9.

The driver subsequently left the van to get something to eat. A short while later, no more than 30 minutes later, another employee, Kerri Bostick, arrived and heard a noise that sounded like children screaming.[3] At first she thought she was hearing children playing. Then, when she walked past the Center's vehicle, she saw Ms. Lea's daughter banging on the window of the van with both hands and calling for her mother. A.M. had gotten hot in the vehicle and wasn't able to open the door. Ms. Bostick observed that A.M. was crying and looked scared. She also noticed that A.M. was sweating. She let the child out of the van and entered the facility with her. The facility staff then transported her to school. The facility's owner and director, Ulo Obadiaru, called Ms. Lea at approximately 9:00 a.m. to apologize for the incident and to ensure Ms. Lea that such an incident would never happen again. The driver also apologized to Ms. Lea after she returned to the facility after her youngest child's eye doctor appointment. Although A.M. did not suffer any lasting physical injuries, her health and welfare were placed in significant danger. (Testimony of A.M.; Testimony of Smith; Testimony of Lea; Testimony of Bostick; Testimony of McNair; Testimony of Ikuadi; Exhibit R-5)

10.

The Center staff did not properly use a passenger transportation checklist to account for the children transported.[4] For example, the Center's staff marked children as either entering or exiting the bus prior to them actually doing so. Additionally, on the day in question, the staff member who completed the "first check," did not comply with the applicable regulations in that she only peered into the window of the van, but did not physically check each row and under the

[3] Ms. Bostick recalls that she arrived at the Center around 8:30 a.m. on August 22, 2013. (Testimony of Bostick)
[4] A passenger transportation checklist in a format provided by Respondent on its website, or another format approved by Respondent, must be used to account for each child during transportation. Ga. Comp. R. and Regs. 591-1-1-.36(6)(c).

seats. Furthermore, the staff did not ensure that another staff member performed a second check. (Testimony of Lea; Testimony of Smith; Testimony of McNair)

11.

On the same day of the incident, the child's mother's cousin called Respondent and reported what had occurred. Specifically, it was alleged that Petitioner left a child in a vehicle unsupervised for one hour. The Department classified the incident as a Category 1 violation, meaning the severity of the allegation required immediate attention. Category 1 violations include allegations that a child has been left in a vehicle, a child has been lost outside the facility, or a child is severely injured. (Testimony of Smith; Testimony of McNair)

12.

The Department assigned Tahishe Smith, a consultant with the Department's complaint unit, to investigate the incident. On August 23, 2013, the day after the incident was reported, Ms. Smith visited the facility. She arrived at approximately 8:45 a.m. to conduct the investigation. (Testimony of Smith) That morning, Ms. Lea chose to complete the second check of the facility's vehicle to ensure no child was on the bus. Typically, Rafaela Camacho, the other Assistant Director, was responsible for completing the second vehicle check in the mornings. (Testimony of Lea; Exhibit R-3)

13.

When Ms. Smith first arrived, Ms. Obadiaru was not present. The Center staff called her and Ms. Smith was able to tell her about the complaint that had been filed. Ms. Obadiaru subsequently arrived at the facility. (Testimony of Smith)

14.

As part of her investigation, Ms. Smith interviewed 9 staff members. She also reviewed video coverage captured by the Center's security cameras of the events that took place the

morning of August 22. Finally, Ms. Smith requested several transportation documents that the facility is required to maintain. The Center's owner fully cooperated with all requests. (Testimony of Smith; Exhibits R-1, R-3, R-4)

15.

A review of the transportation documentation maintained by the facility revealed that, at times, the Center's vehicle transported at least 16 children even though the vehicle only has 15 restraints for the children riding in the passenger portion of the van.[5] Therefore, at least one child was transported without a proper restraint. (Testimony of Smith; Testimony of McNair; Testimony of Rickia Vann, Center employee; Exhibits R-2, R-3, R-4)

16.

Additionally, although the Transportation Log was received Friday morning, the form indicated that all of the children had already been loaded and unloaded for the afternoon, suggesting that the form had been completed prior to the actual events occurring, in violation of Respondent's rules and regulations. It also suggests that the staff was not properly checking children as they entered and exited the van. This is further evidenced by the fact that the form shows that A.M. was unloaded from the bus during the August 22 morning drop-off at Edmons Elementary School even though she was not. (Testimony of Smith; Exhibit R-3)

17.

On the afternoon of August 23, a group consisting of Respondent's regulatory and legal staff reviewed all available data regarding the incident and the Center's history. Based on that review, Respondent determined that the Center's failure to follow transportation rules and regulations placed the children entrusted to the Center's care in imminent danger. Respondent decided to issue an Order for Emergency Closure, which it did on Monday, August 26.

[5] Ms. Lea confirmed that she is aware of times when the number of passengers has exceeded the number of safety restraints on the vehicle. (Testimony of Lea)

Respondent also placed a monitor at the Center to ensure the safety of the children while the Order for Emergency Closure was pending.[6] (Testimony of McNair)

18.

Following the issuance of the Order for Emergency Closure, Respondent's monitor observed that the Center was attempting to comply with the applicable transportation rules and regulations. For example, the monitor observed that the driver and a co-worker completed a vehicle check to ensure no children were on the vehicle. Additionally, Ms. Obadiaru checked the vehicle when all routes had been completed. However, the monitor continued to note concerns. Specifically, it was noted that the Center's staff continued to complete the transportation documentation incorrectly. The staff did not sign the documentation at the time the checks occurred or when children were loaded on and off the bus. Instead, the staff signed the documentation at the end of the route. (Testimony of McNair)

III. CONCLUSIONS OF LAW

1.

The Department bears the burden of proof in this matter. Ga. Comp. R. & Regs. r. 616-1-2-.07. The standard of proof is a preponderance of evidence. Ga. Comp. R. & Regs. r. 616-1-2-.21.

2.

In July 2011, the General Assembly gave the Department's Commissioner the authority to close an early care and education program on an emergency basis for up to twenty-one days. Under O.C.G.A. § 20-1A-13(c)(1), the Commissioner may order an emergency closure under the following circumstances:

[6] Respondent is authorized to place a monitor at the facility pursuant to O.C.G.A. 20-1A-13(b)(1)(C), upon a finding that rules and regulations of the department are being violated that threaten the health, safety, or welfare of children in the program.

(A) Upon the death of a minor at such program, unless such death was medically anticipated or no serious rule violations related to the death by the program were determined by the department; or

(B) Where a child's safety or welfare is in imminent danger.

O.C.G.A. § 20-1A-13(c)(1). Prior to July 2011, the Commissioner's authority in the event of an immediate threat to the health, safety or welfare of a child was restricted to placing a monitor at the Center. See O.C.G.A. § 20-1A-13(b).

3.

Hope for Kids Academy, LLC has failed to comply with the Department's transportation rules, as follows:

(1) 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);

(2) 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(6)(h);

(3) The Center failed to ensure on multiple occasions that the driver or other designated person documented each child's entrance to and exit from the Center's vehicle, in violation of Ga. Comp. R. & Regs. 591-1-1-.36(6)(c)(3);

(4) The Center failed to ensure on multiple occasions that thorough vehicle checks by the driver and another designated staff member occurred after children were unloaded from the vehicle, in violation of Ga. Comp. R. & Regs. 591-1-1-.36(6)(d)(1);

(5) The Center failed to ensure that the number of children being transported did not exceed the manufacturer's rated seating capacity for the vehicle in violation of Ga. Comp. R. & Regs. 591-1-1-.36(2)(f)(2); and

(6) The Center failed to ensure that all children transported in the Center's vehicle were secured in a child passenger restraining system or safety belt in violation of Ga. Comp. R. & Regs. 591-1-1-.36(2)(f)(1).

4.

The Department proved, by a preponderance of the evidence, that the safety and welfare of children at Hope for Kids Academy, LLC are in imminent danger within the meaning of

O.C.G.A. § 20-1A-13(c)(1)(B). The Court's determination is based on the following considerations:

(1) The serious and potentially fatal consequences to a child if the incident that occurred on August 22, 2013, is repeated;

(2) The Center's continuous failure to properly complete required transportation documentation, even after the August 22, 2013 incident and during Bright from the Start's investigation of the Center's transportation procedures;

(3) The Center's failure to properly restrain children while being transported; and

(4) The serious and numerous rule violations stemming from the Center's failure to abide by Bright from the Start transportation and supervision rules.

Accordingly, the Commissioner is authorized to order the emergency closure of Hope for Kids, Academy, LLC for up to twenty-one days, pursuant to O.C.G.A. § 20-1A-13(c)(1). During that time the Center can make the necessary changes recommended at the hearing, such as staffing changes, to ensure that the violations noted above will not be repeated.

IV. DECISION

In accordance with the foregoing Findings of Fact and Conclusions of Law, the Order for Intended Emergency Closure is hereby **AFFIRMED**.

SO ORDERED, this 4th day of September, 2013.

Ana Kennedy
Administrative Law Judge