STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

OAKCREST EARLY EDUCATION CENTER, INC.,	)	
Petitioner,	)	
vs.	)	Case No. 05-2616
DEPARTMENT OF CHILDREN AND FAMILY SERVICES,	)	
Respondent.	)	

RECOMMENDED ORDER

This cause came on for formal proceeding and hearing before P. Michael Ruff, a duly-designated Administrative Law Judge of the Division of Administrative Hearings. The formal hearing was conducted in Ocala, Florida, on October 12, 2005. The appearances were as follows:

APPEARANCES

For Petitioner: Edward L. Scott, Esquire
Edward L. Scott, P.A.
409 Southeast Fort King Street
Ocala, Florida 34471

For Respondent: T. Shane DeBoard, Esquire
Department of Children and Family Services
1601 West Gulf Atlantic Highway
Wildwood, Florida 34785

STATEMENT OF THE ISSUE

The issue to be resolved in this proceeding concerns whether the Department should deny the Petitioner's pending application for a new one-year license effective June 8, 2005, because of an alleged violation that occurred on June 7, 2005, where a three-year-old child was left in a van, suffering purportedly life-threatening injuries (heat stroke). See § 402.305(10), Fla. Stat. and Fla. Admin. Code R. 65C-22.001(5). If the violation occurred, it must also be determined whether denial of license renewal or some other authorized penalty should be imposed.

PRELIMINARY STATEMENT

This cause arose from an incident occurring on June 7, 2005, where the Petitioner allegedly failed to account for all children returning from a field trip at approximately 1:15 in the afternoon. As a result a three-year-old child was allegedly left in one of the Petitioner's vans in violation of Section 402.305(10), Florida Statutes and Florida Administrative Code Rule 65C-22.001(5). The child had to be transported to the emergency department at the local hospital for complications resulting from heat stroke.

An emergency suspension order was entered on June 9, 2005, the license was suspended and all operations at the facility terminated. The Petitioner availed itself of the opportunity to

obtain a Section 120.57(1) formal proceeding to dispute the allegations made by the Department and the cause was transmitted to the Division of Administrative Hearings and the undersigned Administrative Law Judge for resolution.

The cause came on for hearing as noticed. At the hearing the Petitioner presented 11 witnesses and 49 exhibits, all of which were admitted into evidence. The Respondent presented seven witnesses and nine exhibits, all of which were admitted into evidence. Upon concluding the proceeding the parties requested an extending briefing schedule and thereby timely submitted Proposed Recommended Orders which have been considered in the rendition of this Recommended Order after receipt of the transcript.

FINDINGS OF FACT

1. The Petitioner is a large daycare center owned and operated by Joann Jones. It is located in Ocala, Florida and has been licensed since 1992. The Petitioner normally operates its daycare center caring for as many as 250 to 275 children with a staff of 45 to 50 people. The Petitioner and its owner Ms. Jones, has provided child care in Marion County for many years, operating as many as five daycare centers. Ms. Jones has an extensive history in training, education and experience in operating daycare centers and her experience includes working with the former Department of Health and Rehabilitative Services

and the Department of Children and Family Services on various committees and licensing groups for the State of Florida.

2. Prior to the incident on June 7, 2005, the Petitioner had had relatively minor infractions of the Agency's administered statutes and rules involving operation of a daycare center. These infractions primarily included compliance documentation errors and an instance in which a first aid kit did not have all of required the type of supplies, and an instance where a van driver failed to have in his possession and make proper use of a head count check-list on a field trip. In these instances when the Petitioner was found not to be in compliance, compliance was corrected normally by the close of the inspection day when the infraction was discovered. The van driver who failed to have his checklist with him was terminated for violating the Petitioner's policy that a roster including all childrens' names would go on the van at any time the van was being used to transport children.

3. In addition to the above instances, the Petitioner was documented on an inspection checklist on May 13, 2003, for failure to properly maintain a transportation log; for enrollment form violations; for failing to document law enforcement background checks for staff; and for failing to maintain appropriate documentation of Level II screening for

staff members. These were violations of Florida Administrative Code Rules 65C-22.006(4)(5) and 65C-22.001(6)(f).

4. The Petitioner's exhibit thirty-five references a re-inspection from October 9, 2003, and is a checklist. At this time the facility was in violation of Florida Administrative Rule 65C-22.003(2)(a), for failure to have staff appropriately trained and the training certificates documented; for violating Florida Administrative Code Rule 65C-22.004(2)(a), and for failure to maintain first aid kit in the facility's vans and buses (the violation referenced above involving not having all required items in one first aid kit on this occasion). The Petitioner was also in violation of Florida Administrative Code Rule 65C-22.006(2), for failure to properly maintain immunization records and Rule 65C-22.003(2)(a) for failure to properly maintain relevant documentation.

5. An inspection was conducted April 22, 2004. At this time, the facility was in violation of Florida Administrative Code Rule 65C-22.003(2)(a), for failing to document that all staff had completed a 40-hour training course and for failure to properly document the training course.

6. An inspection made April 26, 2005, revealed that the facility was in violation of the proper staff to child ratio established in Section 402.805, Florida Statutes. The proper staff to child ratio on that occasion was 17 to 5 and the

Petitioner, when observed, had a 17 to 4 staff to child ratio. The problem was corrected on the spot that same day.

7. On April 27, 2005, an inspection was conducted and the facility was found to be out of compliance with Florida Administrative Code Rules 65C-22.004(2) and 65C-22.006(5)(d), and Section 435.04, Florida Statutes, for, respectively, failing to properly maintain first aid kits; and failing to properly provide finger prints to the Florida Department of Law Enforcement for the purpose of obtaining required background screening for staff.

8. These prior infractions mostly involved documentation errors rather than actual deficiencies in the operation of the Petitioner's facility and daycare services. The Petitioner has not had a proceeding actually filed against her facility and license by the Department prior to this one, with the possible exception of an occurrence some seven years ago when the Petitioner received a $100.00 fine related to a documentation error. These prior infractions were not shown to have been serious ones involving an immediate threat to the health or safety of the children in Petitioner's care. Most of these infractions were shown to have been corrected on the same day they were noted on the relevant inspection reports.

9. A three-year-old child was inadvertently left in a van when it was returned and parked at Petitioner's daycare center,

on June 7, 2005. this incident caused the instant proceeding to deny the Petitioner's re-licensure. On that day two vans from the Petitioner's facility left to take a group of three-year-olds on an outing for lunch for pizza party. On that date the Petitioner had in operation, policies that required all teachers to keep rolls of their children, to count their children every hour and to complete a log which was to be turned into the directors of the daycare center at the end of the day. The Petitioner was responsible for providing these logs to the Respondent Agency upon routine inspections.

10. There was also a policy in effect regarding operation of vans and buses for transportation of children. The teachers and bus drivers were required to keep a log of the children riding on the vans. The teachers were required to take a "head count" when the children left the classroom and when they entered and exited the vans or buses. The teachers were required to carry a roll with all the children's names with them at all times. They were required to carry this roll on a clip board and this policy even if the teachers took the children out on the playground, where they were still required to do head counts. The Petitioner held meetings periodically with its employees and informed them regarding the policy concerning head counts and the log for using the vans, which involved head counts.

11. Ladonna Cunningham was a van driver for the Petitioner on the date in question, June 7, 2005. She established that she was aware of the policy of counting children before they got on the van, after they got on the van, and when they got off the van again, as well as the fact that the vans were to be checked ("van sweeps") after all the children were off the van to make sure that no one was still on the van. On June 7, 2005, she and the teacher going on the field trip with her van, Katrice Robinson, counted their children and Katrice did a van sweep when they returned to the daycare center after the trip. Ladonna Cunningham did a second van sweep to make sure that there were no children on her van and was aware that this was in accordance with the Petitioner's policy.

12. On June 7, 2005, a three-year-old child (N.B.) was taken on the field trip to the pizza party. The van returned to the daycare center sometime after 1:40 p.m. There were two vans used on this field trip. One van was driven by Ladonna Cunningham, accompanied by the teacher Katrice Robinson. The second van, with N.B. aboard, was operated and supervised by two other employees, Amina Francious and Regina Brown. Neither Francious nor Brown made a head count of the children or a van sweep after returning to the daycare center. Regina Brown told investigators that she knew they were supposed to make a head count when they returned to the daycare center that day but

neither she nor Amina Francios had done so. The evidence also shows that Katrice Robinson, who was N.B.'s teacher, "checked him off" as being in the classroom at 2:00 p.m., that day for a snack when he was in fact outside in the closed van. This erroneous fact was entered by Katrice Robinson on the head count sheet provided by the Petitioner. All teachers are required to make a head count every 30 minutes and to note the time a meal, snack, or lunch is served to a child.

13. Later that afternoon the child N.B. was discovered either asleep or unconscious in the closed van which had been parked in the hot sun. The child was difficult to arouse or unresponsive and had an external Fahrenheit temperature of 104 degrees. At 4:02 p.m., he was taken by EMS personnel to the hospital where he was ultimately diagnosed with hyperthermia or heat stroke. He was unresponsive, having seizures, actively vomiting, and had to be intubated since his left lung had collapsed. The Department received abuse report 2005-396658 as a result of this incident. Fortunately, the child recovered.

14. On June 8, 2005, Ms. Littell, a Department representative interviewed the three employees, Regina Brown, Katrice Robinson, and Amina Francois. Both Ms. Francios and Ms. Brown admitted failing to conduct a van sweep after they returned to the Petitioner's facility on June 7, 2005. All three of these employees were arrested for felony child neglect.

These interviews, as well as Petitioner's owner and operator Joann Jones, in her testimony, confirmed that on June 8, 2005, the Petitioner's assistant director Irma Ramjit, had asked Ms. Francois and Ms. Brown to sign for an employee handbook that they had never actually received. Thus Ms. Ramjit had asked these employees to falsify documentation after the child had been left in the van, in an apparent attempt to show that the facility had followed its own procedures when in fact it had not. This action by Ms. Ramjit was not at the behest or condoned of the Petitioner's owner, Ms. Jones, however.

15. The abuse report referenced above was ultimately closed and finalized as "verified for neglect and inadequate supervision" as a result of the child being left in the van. Physical injury had occurred as a result of the physical injury suffered by the child from heat exposure. Obviously the Petitioner's policy of conducting head counts every 30 minutes was not done properly on June 7, 2005. Indeed, the last head count for the class of the child who was left on the van was conducted at 9:30 a.m., on June 7, 2005.

16. Joann Jones the Petitioner's owner was shocked and devastated by the events of June 7, 2005. She had never had such an occurrence previously in the 20 years she had been engaged in the daycare business. After this incident happened and before the issue regarding her license arose she had already

acted to ban any further field trips for three-year-old children and had elected to hire a person to perform nothing but head counts each day to make sure that the policy was carried out and such an event never again occurred.

17. The evidence shows that the Petitioner's facility has otherwise been operated in a quality manner, as shown by the testimony of Kimberly Webb. Ms. Webb was an employee of the Petitioner for some 15 years and was well aware of the Petitioner's rules concerning conducting head counts of children, doing "van sweeps" and the general policies to ensure child safety in the day-to-day operations of the care center.

18. Marjorie McGee is employed by Child Hood Development Services and testified for the Petitioner. Ms. McGee went to the daycare center on numerous occasions to monitor the Childhood Development Services Program and the Head Start Program. Ms. McGee observed that Ms. Jones and the daycare center staff provided quality child care. Any concerns she ever had were immediately addressed and corrected by Ms. Jones or one of the directors of the center. Ms. McGee, in fact, established that the Petitioner's facility in one of the highest-rated daycare centers in Marion County. This testimony is corroborated by several parents who testified concerning the operation of the daycare center and by Juanita Thompson, who works as a childhood curriculum specialist and over the years

had done consulting for the Petitioner in preparing curriculums. She attested to the high quality care provided by the Petitioner.

CONCLUSIONS OF LAW

19. The Division of Administrative Hearings has jurisdiction of the subject matter of and the parties to this proceeding. § 120.569 and 120.57(1), Fla. Stat. (2005).

20. The burden of persuasion rests on the Petitioner in this case to prove entitlement to the license. Department of Banking and Finance Division of Securities and Investor Protection v. Osborne Stern and Co., 670 So. 2d 932, 934 (Fla. 1996) (wherein the court emphasized that while the burden of producing evidence may shift between parties in an application dispute proceeding that the burden of persuasion remain upon the applicant to prove entitlement to the license).

21. Section 402.310(1)(a), Florida Statutes, provides that the Department may deny a license for violation of any provision of Sections 402.301 through 402.319, Florida Statutes, or the Rules adopted thereunder. Section 402.310(1)(a), states:

> The Department or licensing agency may deny, suspend, or revoke a license or impose an administrative fine not to exceed $100.00 per violation, per day, for the violation of any provision of §§ 401.301 - 402.319 or rules adopted thereunder. However, where the violation could or does cause death or serious harm, the Department or local licensing agency may impose an

> administrative fine, not to exceed $500.00 per violation per day.
>
> (b) In determining the appropriate disciplinary action to be taken for a violation as provided in paragraph (a) the following factors shall be considered:
>
> 1. The severity of the violation, including the probability that death or serious harm to the health or safety of any person will result or has resulted, the severity of the actual or potential harm, and the extent to which the provisions of §§ 402.301 - 402.319 have been violated.
>
> 2. Actions taken by the licensee to correct the violation or to remedy complaints.
>
> 3. Any previous violations of the licensee.

22. There is no question, in considering the standard expressed in the language of this statute, that the violation is a severe one because N.B. can be considered to be injured and indeed that the risk of serious harm or even death was posed by the neglect which occurred, even though it was accidental and unintentional. There were also previous violations on the part of the licensee, albeit themselves not serious violations or those which posed serious threat of actual or potential harm under their circumstances. It is also true that the licensee, by Ms. Joann Jones, took immediate action to correct the problem to ensure that such an event never again will occur.

23. There is no question that Ms. Jones is a very caring and generally competent provider of child care as operator of

the facility. When the paramedics came she assisted them and rode in the ambulance to the hospital with N.B. She stayed at the hospital to make sure that he was well taken care of and took immediate steps to inform his family. Upon the immediate alleviation of the crisis, from which N.B. recovered, she took immediate steps to terminate the personnel at fault and to see that no further field trips for children that young were taken. She also vowed as well to retain a person who would in the future do nothing but head counts and van sweeps to make sure that such an event never again occurred. Obviously, before this step could be enacted she had her license suspended on an emergency basis and the re-licensure denied, with operations of the facility halted. It is somewhat curious that the evidence reflects that the Respondent never made any contact with Joann Jones after it began investigating the incident to ascertain what her response to the incident was, what steps she took or planned to take in the immediate future to avoid its ever occurring again nor to find out what her knowledge of any facts surrounding the incident might be.

24. Unfortunately, the violations that have occurred were proven and indeed the Petitioner never contested that they occurred. The Petitioner, in essence, attempted to explain steps that she took or would take, if given the opportunity by remaining licensed, to see that the violations never occurred

again in the future. She also established that the violations occurring in the past, before the subject incident, had been corrected on the spot or before re-inspection, generally the same day they were brought to her attention.

25. Nevertheless, one cannot change the fact that the violations occurred and that the violation involving the child being left in the heat in the vehicle was a severe and serious violation. It is unfortunate that even a well-meaning operator such as Ms. Jones cannot undo the injury that has already occurred to a child by claiming to have corrected the violation that occasioned the injury or promising changed policies in the future to ensure its never occurring again. This is not a substitute for correcting a problem before the injury to the child ever occurred.

26. Accordingly, in view of the severity of the violation of June 7, 2005, even though it was an isolated occurrence, and even though it occurred because the Petitioner's staff was negligent and betrayed the Petitioner, it is appropriate to deny the new one-year license which the Petitioner had applied-for as of April 11, 2005. This conclusion is made in consideration of the severity of this June 7, 2005, incident, coupled with the Petitioner's history of violations, which themselves were relatively minor, had they not been compounded by the injury to N.B. It is also true that there is no reason, based upon the

evidence, in this record, that the Petitioner should not be re-licensed at such time in the future as appropriate monitoring by the Department ensures that operations at the daycare center can be begun again with proper methods of operation and documentation.

RECOMMENDATION

Having considered the foregoing Findings of Fact, Conclusions of Law, the evidence of record, the candor and demeanor of the witnesses, and the pleadings and arguments of the parties, it is, therefore,

RECOMMENDED that a final order be entered by the Department of Children and Family Services denying licensure to the Petitioner, Oakcrest Early Education Center, Inc., effective with the application of April 11, 2005, without prejudice to the Petitioner re-applying for licensure in June 2006, in conjunction with an appropriate monitoring program by the Respondent Agency designed to ensure that all operational and documentation provisions of the applicable statutes and rules are complied with upon an ongoing basis.

DONE AND ENTERED this 14th day of March, 2006, in Tallahassee, Leon County, Florida.

P. MICHAEL RUFF
Administrative Law Judge
Division of Administrative Hearings
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Filed with Clerk of the
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NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the Final Order in this case.