

STATE OF MINNESOTA  
OFFICE OF ADMINISTRATIVE HEARINGS  
FOR THE DEPARTMENT OF HUMAN SERVICES

In the Matter of the Revocation of the  
Family Child Care License of Melissa Born  
and the Maltreatment Determination and  
Disqualification of Melissa Born

**FINDINGS OF FACT,  
CONCLUSIONS OF LAW,  
AND RECOMMENDATION**

This matter came before Administrative Law Judge Perry Wilson for hearing on June 28, 2016, at the Wright County Human Services Building in Buffalo, Minnesota. The record closed at the end of the hearing on June 28, 2016.

Karen Wolff, Assistant Wright County Attorney, appeared on behalf of the Minnesota Department of Human Services (Department). Deborah Eckland, Goetz & Eckland, appeared on behalf of Appellant Melissa Born (Appellant).

**STATEMENT OF THE ISSUES**

1. Did maltreatment of a child occur for which Appellant is responsible under Minn. Stat. § 626.556, subd.10e(e) (2014)?
2. Should Appellant's Family Child Care License be revoked?

**SUMMARY OF RECOMMENDATION**

The Administrative Law Judge recommends that:

1. the finding of maltreatment of a child by Appellant be **AFFIRMED** as supported by a preponderance of the evidence; and,
2. the revocation of Appellant's Family Child Care License be **AFFIRMED**.

Based upon the submissions of counsel and the hearing record the Administrative Law Judge makes the following:

## FINDINGS OF FACT

1. Appellant operated a child day care facility out of her home in Otsego, Minnesota from 2007 to August 21, 2015, when the Department issued an Order of Temporary Immediate Suspension.<sup>1</sup>

2. On the morning of August 20, 2015, three-month-old M.H.'s mother woke her up, changed her, fed her, and dropped her off at Appellant's home day care at 6:45 a.m.<sup>2</sup> M.H. had been attending Appellant's day care for three weeks.<sup>3</sup>

3. When M.H. arrived at Appellant's facility she was behaving normally and had no apparent physical problems.<sup>4</sup>

4. At approximately 10:00 a.m. on August 20, 2015, M.H. became fussy and Appellant attempted to sooth her by giving her a bottle and putting her down for a nap.<sup>5</sup> When M.H. awoke from her nap she was fussy again. Appellant attempted to give her a bottle, which M.H. refused.<sup>6</sup>

5. Shortly before 12:00 p.m., Appellant changed M.H.'s diaper on the floor in the basement day care area of her home.<sup>7</sup> When she was in the middle of the diaper change, Appellant noticed that M.H. was struggling to breath.<sup>8</sup> Appellant quickly completed the diaper change and went out in her back yard with M.H. Appellant gave M.H. to her neighbor and called M.H.'s mother.<sup>9</sup>

6. Appellant's neighbor, while holding M.H., noticed that she was struggling to breathe, that her eyes had rolled back, and that M.H.'s tongue had rolled back. The neighbor called 911.<sup>10</sup> Appellant also called 911, after speaking with M.H.'s mother.<sup>11</sup>

7. M.H. was transported by ambulance to Mercy Hospital, where she was examined and a CT scan of her head was performed.<sup>12</sup> The CT scan showed a subdural hemorrhage of M.H.'s brain.<sup>13</sup> The treating physician suspected child abuse caused the hemorrhage and referred M.H. to Children's Hospital for further investigation and treatment.<sup>14</sup>

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<sup>1</sup> Testimony (Test.) of Melissa Born.

<sup>2</sup> Test. of Sarah Hase.

<sup>3</sup> *Id.*

<sup>4</sup> *Id.*

<sup>5</sup> Test. of M. Born.

<sup>6</sup> *Id.*

<sup>7</sup> *Id.*

<sup>8</sup> *Id.*

<sup>9</sup> *Id.*

<sup>10</sup> Ex. 134.

<sup>11</sup> Exs. 2, 2a.

<sup>12</sup> Ex. 6.

<sup>13</sup> *Id.*

<sup>14</sup> *Id.*

8. M.H. was transported by ambulance to Children’s Hospital where she was seen by Dr. Mark Hudson.<sup>15</sup>

9. Dr. Hudson is a specialist in child abuse medicine and is board certified in Pediatrics and Child Abuse Pediatrics.<sup>16</sup> Dr. Hudson has extensive experience in child abuse evaluation and prevention.<sup>17</sup>

10. Dr. Hudson took a history of M.H.’s illness, considered her past medical history, her family and social history, conducted a physical examination and reviewed the CT scan performed at Mercy Hospital.<sup>18</sup> Based on this evaluation, Dr. Hudson reached the opinion that M.H.’s subdural hemorrhage was the result of trauma and that the trauma “most likely” occurred “immediately prior to the onset of neurologic symptoms.”<sup>19</sup>

11. At the hearing Dr. Hudson testified that it is more likely than not that the injury to M.H. occurred immediately prior to the onset of her symptoms.<sup>20</sup> On cross examination, Dr. Hudson testified that his opinion as to the timing of the injury is based on a reasonable degree of medical certainty.<sup>21</sup>

12. M.H. was frequently fussy during her time in Appellant’s care.<sup>22</sup> Appellant kept a log of her care of M.H., which indicated that she was fussy and difficult to calm.<sup>23</sup> Appellant exchanged text messages with M.H.’s mother on August 17, 2015, in which she asked for suggestions as to how she could calm M.H., who was very unhappy and crying constantly.<sup>24</sup>

13. Appellant’s neighbor stated that M.H. has a very high-pitched cry which she could hear while in her own house.<sup>25</sup> The neighbor stated that M.H. was a really unhappy baby who Appellant could not calm.<sup>26</sup>

14. Wright County Child Protection began an investigation of the injury to M.H. on August 20, 2015.<sup>27</sup> The Wright County Sheriff’s Office began conducting a criminal investigation into M.H.’s injury on August 21, 2015.<sup>28</sup> Beginning on August 21, 2015, Child Protection and the Sheriff conducted a joint investigation of the injury.<sup>29</sup>

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<sup>15</sup> Test. of Dr. Mark Hudson.

<sup>16</sup> *Id.*; Hudson C.V., attached to Hudson Witness Statement, dated January 22, 2016.

<sup>17</sup> Test. of M. Hudson.

<sup>18</sup> Ex. 7.

<sup>19</sup> *Id.*

<sup>20</sup> Test. of M. Hudson.

<sup>21</sup> *Id.*

<sup>22</sup> Test. of M. Born.

<sup>23</sup> Ex. 103.

<sup>24</sup> Ex. 101.

<sup>25</sup> Test. of Amy VanHouten.

<sup>26</sup> *Id.*

<sup>27</sup> Test. of Molly Martie.

<sup>28</sup> Ex. 8.

<sup>29</sup> Test. of M. Martie.

15. The investigators conducted interviews of M.H.'s mother and father on August 21, 2015 at Children's Hospital.<sup>30</sup> Before conducting the interviews, the Child Protection worker was informed by Dr. Hudson that M.H.'s injury was non-accidental and that it was most probable that the injury to M.H. occurred immediately before the onset of symptoms.<sup>31</sup>

16. The investigators were told by M.H.'s mother and father, who were interviewed separately, that M.H. was healthy when she arrived at Appellant's day care on August 20, 2015. Neither parent could recall any event that could have caused M.H.'s injury when she was in their care.<sup>32</sup> The parents denied that M.H. had suffered any injury while they were on a camping trip from August 13, 2015 to August 16, 2015, and stated that during this trip M.H. was always in their care.<sup>33</sup>

17. M.H.'s father spontaneously told the investigators that he did not shake or hurt M.H. in any way.<sup>34</sup>

18. The investigators interviewed Appellant at her home on August 21, 2015.<sup>35</sup> Appellant stated that nothing happened to M.H. while she was in Appellant's care that could have caused her injury.<sup>36</sup> When she was pushed by the Deputy Sheriff, Appellant stated that she may have put M.H. down too quickly on the mat to change M.H.'s diaper, but that this could not have caused M.H.'s injury.<sup>37</sup>

19. While interviewing Appellant, the Deputy Sheriff believed that her demeanor changed, when the Deputy told her that she was not under arrest.<sup>38</sup> The Deputy stated in his report that: "[a]t that point her eye contact became very poor, she looked down and her statements became choppy. [Appellant's] face became tense and it looked like her eyes became glassy and watery."<sup>39</sup>

20. On August 21, 2015, Wright County Human Services workers recommended that the Department issue a Temporary Immediate Suspension of Appellant's license.<sup>40</sup> This recommendation was based on the interviews conducted and the opinion of Dr. Hudson that the onset of M.H.'s symptoms most likely occurred right after she was injured.<sup>41</sup>

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<sup>30</sup> Ex. 8.

<sup>31</sup> *Id.*

<sup>32</sup> *Id.*

<sup>33</sup> *Id.*

<sup>34</sup> *Id.*

<sup>35</sup> *Id.*

<sup>36</sup> *Id.*

<sup>37</sup> *Id.*

<sup>38</sup> *Id.*

<sup>39</sup> *Id.* In contrast, the Deputy noted that M.H.'s parents both maintained good eye contact throughout their interviews. *Id.*

<sup>40</sup> Ex. 11.

<sup>41</sup> *Id.*

21. On August 21, 2015, the Department issued its order temporarily and immediately suspending Appellant's license.<sup>42</sup>

22. On October 6, 2015, Wright County Child Protection determined that M.H. was maltreated while in Appellant's care and that Appellant was responsible for the maltreatment.<sup>43</sup> Appellant's counsel requested reconsideration of the maltreatment determination by letter dated October 26, 2015. Wright County determined that the maltreatment determination should not be set aside.<sup>44</sup>

23. On November 17, 2015, Wright County Human Services recommended that the Department issue an order revoking Appellant's license based on the maltreatment determination.<sup>45</sup>

24. On December 14, 2015, the Department issued its order revoking Appellant's license.<sup>46</sup> The revocation of Appellant's license by the Department was based on the maltreatment determination.<sup>47</sup>

25. On December 21, 2015, Appellant filed a notice appealing the Department's order revoking her license.<sup>48</sup>

26. On May 9, 2016, Dr. Donald Chadwick reviewed M.H.'s medical records at the request of Appellant's counsel and provided a report of the results of his review.<sup>49</sup> Dr. Chadwick is a Pediatric Neurologist at the Minneapolis Clinic of Neurology.<sup>50</sup> Dr. Chadwick found that M.H.'s subdural hematoma is suggestive of trauma. Dr. Chadwick stated that: "[w]ith the CT report suggesting acute hemorrhage, I would presume that this would have been within the last 24 to maybe 48 hours. The event she had could have been a seizure."<sup>51</sup>

### **Appellant's Licensing History**

27. On February 26, 2010, the mother of a child in Appellant's care reported that the child broke her arm when she was hit by a falling pack and play.<sup>52</sup>

28. On March 1, 2010, a Wright County child protection worker and a licensing worker made an unannounced visit to Appellant's day care home to investigate how the

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<sup>42</sup> Ex. 109.

<sup>43</sup> Ex. 12.

<sup>44</sup> Ex. 14.

<sup>45</sup> Ex. 15.

<sup>46</sup> Ex. 16.

<sup>47</sup> *Id.*

<sup>48</sup> Notice and Order for Hearing filed January 4, 2016, Ex. A.

<sup>49</sup> Ex. 108.

<sup>50</sup> *Id.*

<sup>51</sup> *Id.*

<sup>52</sup> Ex. 17.

child's arm was broken.<sup>53</sup> They discovered that Appellant was in her basement with the children in her care.<sup>54</sup>

29. In the basement were toys, games, puzzles, mats and other day care items.<sup>55</sup> One infant was asleep in a pack and play in a basement room that also contained two empty pack and plays and a working electric saw.<sup>56</sup> A blanket was in the pack and play with the infant.<sup>57</sup>

30. Appellant's basement was not licensed for day care operation.<sup>58</sup> The licensing worker asked Appellant if she was operating her day care in the basement.<sup>59</sup> Appellant stated that she was not operating her day care in the basement.<sup>60</sup>

31. Appellant admitted that she lied to the licensing worker and that she was operating her day care in the basement on March 1, 2010.<sup>61</sup>

32. Appellant received a Correction Order resulting from the violations of law and rule discovered by the Wright County representatives in her day care on March 1, 2010.<sup>62</sup>

33. On July 29, 2010, Wright County received a report that a ten-month-old child suffered a broken femur while in Appellant's care.<sup>63</sup> Appellant explained to the investigators that child was climbing on a slide when he fell, bumping his leg on the slide.<sup>64</sup> The slide was not designed for use by a ten-month-old child.<sup>65</sup>

34. Appellant received a Correction Order, dated August 2, 2010, indicating that she violated applicable rules when she allowed a child in her care to play with equipment not recommended for his age and when she failed to supervise the child.<sup>66</sup>

35. On July 23, 2010, Wright County Human Services recommended that the Department issue Appellant a conditional license.<sup>67</sup> The conditional license was recommended because of the violations of law and rule found in Appellant's day care on March 1, 2010 and July 29, 2010.<sup>68</sup>

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<sup>53</sup> *Id.*

<sup>54</sup> *Id.*

<sup>55</sup> *Id.*

<sup>56</sup> *Id.*

<sup>57</sup> *Id.*

<sup>58</sup> *Id.*

<sup>59</sup> *Id.*

<sup>60</sup> *Id.*

<sup>61</sup> Test. of M. Born.

<sup>62</sup> Ex. 17.

<sup>63</sup> Ex. 18.

<sup>64</sup> *Id.*

<sup>65</sup> *Id.*

<sup>66</sup> *Id.*

<sup>67</sup> Ex. 20.

<sup>68</sup> *Id.*

36. On March 23, 2011, the Department issued a conditional license to Appellant based on the recommendation of Wright County.<sup>69</sup> The two-year conditional license required Appellant to make numerous changes in the way she operated her day care.<sup>70</sup> The required changes included submission of detailed plans for supervision of children in her care and for the safety of children in her care, including compliance with the Sudden Infant Death Syndrome protocol for sleeping infants.<sup>71</sup>

37. In addition, the conditional license required Appellant to attend eight hours of training on child development and safety and set limits on the number of children who could be in Appellant's care.<sup>72</sup>

38. Appellant requested reconsideration of the conditional license.<sup>73</sup> The Department denied the request for reconsideration, but did reset the dates by which Appellant was required to comply with the conditions.<sup>74</sup>

### **Appellant's Statements of Support**

39. Appellant has provided 14 emails and parental evaluation forms as a part of the record.<sup>75</sup> Two of the emails are from Appellant's neighbors.<sup>76</sup> Two of the emails are from individuals with whom Appellant did business in connection with her day care.<sup>77</sup> Ten of the statements of support are from parents who had their children in Appellant's care.<sup>78</sup>

40. The statements of support by parents are emails and evaluation forms provided to the parents by Wright County.<sup>79</sup> These documents range in date from 2008 to 2016. The parents uniformly praise Appellant's operation of her day care.<sup>80</sup> Many of the parents noted that Appellant is a warm and caring provider.<sup>81</sup>

41. M.H.'s parents do not feel any ill will towards Appellant and have been in contact with her socially since M.H.'s injury.<sup>82</sup>

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<sup>69</sup> Ex. 21.

<sup>70</sup> *Id.*

<sup>71</sup> *Id.*

<sup>72</sup> *Id.*

<sup>73</sup> Ex. 22.

<sup>74</sup> *Id.*

<sup>75</sup> Exs. 113-126

<sup>76</sup> Exs. 116, 118.

<sup>77</sup> Exs. 115, 117.

<sup>78</sup> Exs. 113-115, 117, 119-126.

<sup>79</sup> *See, e.g.*, Exs. 113, 123.

<sup>80</sup> Exs. 113-126.

<sup>81</sup> *See, e.g.*, Exs. 113, 119.

<sup>82</sup> Test. of S. Hase; Test. of Zachary Hase.

Based upon these Findings of Fact, the Administrative Law Judge makes the following:

### **CONCLUSIONS OF LAW**

1. The Administrative Law Judge and the Commissioner of the Department of Human Services (Commissioner) are authorized to consider an appeal of a maltreatment determination, revocation and disqualification pursuant to Minn. Stat. §§ 245A.08, subd. 2a(a); 626.556, subd. 10i(f); 14.50 (2014).

2. Appellant received due, proper and timely notice of the basis for the Department's decision and of the time and place of the hearing. This matter is, therefore, properly before the Commissioner and the Administrative Law Judge.

3. In this case, the Department has the burden to establish by a preponderance of the evidence that evidence exists to support the serious maltreatment determination. Minn. Stat. § 626.556, subd. 10e(e).

4. Minnesota Statute, section 245C.02, subdivision 18 (2014), defines serious maltreatment as:

(a) "Serious maltreatment" means sexual abuse, maltreatment resulting in death, neglect resulting in serious injury which reasonably requires the care of a physician whether or not the care of a physician was sought, or abuse resulting in serious injury.

(b) For purposes of this definition, "care of a physician" is treatment received or ordered by a physician, physician assistant, or nurse practitioner, but does not include:

(1) diagnostic testing, assessment, or observation;

(2) the application of, recommendation to use, or prescription solely for a remedy that is available over the counter without a prescription; or

(3) a prescription solely for a topical antibiotic to treat burns when there is no follow-up appointment.

(c) For purposes of this definition, "abuse resulting in serious injury" means: bruises, bites, skin laceration, or tissue damage; fractures; dislocations; evidence of internal injuries; head injuries with loss of consciousness; extensive second-degree or third-degree burns and other burns for which complications are present; extensive second-degree or third-degree frostbite and other frostbite for which complications are present; irreversible mobility or avulsion of teeth;

injuries to the eyes; ingestion of foreign substances and objects that are harmful; near drowning; and heat exhaustion or sunstroke.

5. Minnesota Statutes section 245A.08, subd. 2a (2014), provides:

When a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, subdivision 3, is based on a disqualification for which reconsideration was timely requested and which was not set aside under section 245C.22, the scope of the contested case hearing shall include the disqualification and the licensing sanction or denial of a license, unless otherwise specified in this subdivision. When the licensing sanction or denial of a license is based on a determination of maltreatment under section 626.556 or 626.557, or a disqualification for serious or recurring maltreatment which was not set aside, the scope of the contested case hearing shall include the maltreatment determination, disqualification, and the licensing sanction or denial of a license, unless otherwise specified in this subdivision. In such cases, a fair hearing under section 256.045 shall not be conducted as provided for in sections 245C.27, 626.556, subdivision 10i, and 626.557, subdivision 9d.

6. The Department proved by a preponderance of the evidence that M.H.'s subdural hemorrhage occurred while she was in Appellant's care on August 20, 2015. M.H. received internal injuries resulting in the care of a physician and hospitalization.

7. The injury to M.H. that resulted in her subdural hemorrhage was shown, by a preponderance of the evidence, to be the result of maltreatment of M.H. while she was in Appellant's care, within the meaning of Minn. Stat. § 626.556, subd. 10e(e), and physical abuse within the meaning of Minn. Stat. § 245C.02, subd. 18.

8. The finding of serious maltreatment of M.H. by Appellant is supported by a preponderance of the evidence and should not be set aside.

9. The revocation of Appellant's family child care license is based upon the finding of maltreatment, which is supported by a preponderance of the evidence, and the revocation should not be set aside.

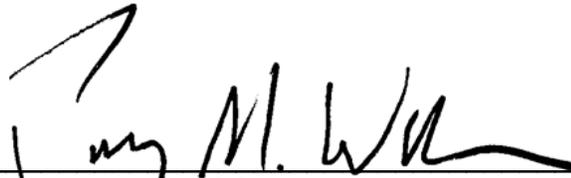
Based upon the foregoing Findings of Fact and Conclusions of Law, and for the reasons set forth in the attached Memorandum, the Administrative Law Judge makes the following:

## RECOMMENDATION

### IT IS HEREBY RECOMMENDED:

That the Department's determination Appellant committed maltreatment be **AFFIRMED** and that the revocation of Appellant's Family Child Care License, based upon the finding of maltreatment, be **AFFIRMED**.

Dated: July 27, 2016



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PERRY M. WILSON  
Administrative Law Judge

Digitally recorded; no transcript prepared.

## NOTICE

This Report is a recommendation, not a final decision. The Commissioner will make the final decision after a review of the record. Under Minn. Stat. § 14.61 (2014), the Commissioner shall not make a final decision until this Report has been made available to the parties for at least ten calendar days. The parties may file exceptions to this Report and the Commissioner must consider the exceptions in making a final decision. Parties should contact Debra Schumacher, Administrative Law Attorney, PO Box 64998, St. Paul MN 55164, (651) 431-4319 to learn the procedure for filing exceptions or presenting argument.

The record closes upon the filing of exceptions to the Report and the presentation of argument to the Commissioner, or upon the expiration of the deadline for doing so. The Commissioner must notify the parties and Administrative Law Judge of the date the record closes. If the Commissioner fails to issue a final decision within 90 days of the close of the record, this Report will constitute the final agency decision under Minn. Stat. § 14.62, subd. 2a (2014). In order to comply with this statute, the Commissioner must then return the record to the Administrative Law Judge within ten working days to allow the Judge to determine the discipline imposed.

Under Minn. Stat. § 14.62, subd. 1 (2014), the Commissioner is required to serve its final decision upon each party and the Administrative Law Judge by first class mail or as otherwise provided by law.

## MEMORANDUM

The facts in this case are to be judged by the preponderance of the evidence standard set forth in Minn. Stat. § 626.556, subd.10e(e). In *City of Lake Elmo v. Metropolitan Council*,<sup>83</sup> the Minnesota Supreme Court stated the following regarding the preponderance of the evidence standard:

The preponderance of the evidence standard requires that to establish a fact, it must be more probable that the fact exists than that the contrary exists. *Netzer v. N. Pac. Ry. Co.*, 238 Minn. 416, 425, 57 N.W.2d 247, 253 (1953). If evidence of a fact or issue is equally balanced, then that fact or issue has not been established by a preponderance of the evidence. *Id.* The preponderance of the evidence standard is a higher standard than the substantial evidence standard set forth in section 14.69, which is the typical evidentiary standard applied by appellate courts when reviewing agency decisions.<sup>84</sup>

Applying the preponderance of the evidence standard, the Administrative Law Judge finds that the Department has met its burden of proof, because it showed that it is more probable than not that Appellant is responsible for the subdural hematoma suffered by M.H. The medical evidence provided by Dr. Hudson was that M.H.'s brain injury occurred shortly before the onset of her symptoms. Since M.H.'s symptoms occurred at Appellant's day care, after she had been in Appellant's care for approximately five hours, it is more probable than not that the injury occurred in Appellant's care. The mechanism by which M.H. suffered trauma to her head, causing the subdural hematoma, was not shown and there was no bruising to M.H.'s head.

The critical issue in this case is whether Dr. Hudson's opinion that M.H.'s symptoms occurred shortly after the trauma that caused her injury is sufficient evidence of the timing of the injury to support the conclusion that Appellant more likely than not caused the injury to M.H. Appellant presented the written opinion of Dr. Donald Chadwick that: "[w]ith the CT report suggesting acute hemorrhage, I would presume that this would have been within the last 24 to maybe 48 hours. The event she had could have been a seizure."

The Administrative Law Judge does not find that the opinions of Dr. Hudson and Dr. Chadwick conflict on the critical point of the timing of the injury. Dr. Chadwick states a range of time within which the injury could have occurred. Dr. Hudson testified that the injury occurred within the range posited by Dr. Chadwick.

Even if the medical opinions as to the timing of the injury did conflict, Dr. Hudson examined M.H. shortly after she suffered symptoms of the injury. In addition, Dr. Hudson is board certified in Pediatrics and Child Abuse Pediatrics and has extensive practice

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<sup>83</sup> 685 N.W.2d 1 (Minn. 2004).

<sup>84</sup> *Id.* at 4.

experience in these areas. Finally, Dr. Hudson was subjected to cross-examination, during which he affirmed his opinion on the timing of the injury. The Administrative Law Judge finds that Dr. Hudson's opinion is more reliable and more precise than Dr. Chadwick's opinion.

Appellant argues that the Minnesota Court of Appeals decision in *In the Matter of the Temporary Immediate Suspension of the Family Child Care License of Christine Strecker*, 777 N.W.2d 41 (Minn. Ct. App. 2010) is factually similar to this case and that the court of appeals' conclusion that the evidence did not support the temporary suspension of Strecker's license should persuade the Administrative Law Judge that the evidence supporting the maltreatment determination and license revocation here is insufficient. The Department argues that *Strecker* is not persuasive because the burden of proof is different and the facts of the cases are different.

The Administrative Law Judge agrees with the Department that facts of *Strecker* are significantly different than the facts of this case. It is true that the infants in both the *Strecker* case and this one suffered subdural hemorrhages.<sup>85</sup> Both infants developed symptoms of their injury while in day care.<sup>86</sup> In both cases, the day care provider and the parents denied any part in the injury.<sup>87</sup> In both cases, Dr. Mark Hudson provided medical evidence and an opinion supporting the Department's position.<sup>88</sup> Each day care provider submitted substantial evidence that the parents of other children in care supported the provider.<sup>89</sup> The parents of each injured child remained supportive of the provider.<sup>90</sup> The similarities end at this point.

The decision in *Strecker* was based on the medical evidence offered. In *Strecker*, the Department offered the report of Dr. Hudson, which stated, as described by the court, in part, that: "[w]hen this injury occurred remains somewhat unclear." His report notes that retinal hemorrhages cannot be dated accurately and further notes that the acute nature of J.H.'s subdural hematoma suggested that it could have occurred on September 16 or in the days before.<sup>91</sup> Medical evidence was also provided by the reports of two physicians who provided evidence for the licensee. One physician's report stated that the injury had occurred three to five days before the onset of symptoms based on the deterioration of the blood on the infant's brain, as shown by an MRI.<sup>92</sup> The other physician's report stated that his review of the report of the ophthalmological examination, showing that the infant had suffered retinal hemorrhages as a part of the injury, indicated that those hemorrhages had been present for five to seven days before the onset of symptoms.<sup>93</sup>

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<sup>85</sup> 777 N.W.2d at 42.

<sup>86</sup> *Id.*

<sup>87</sup> *Id.* at 43.

<sup>88</sup> *Id.*

<sup>89</sup> *Id.* at 47.

<sup>90</sup> *Id.*

<sup>91</sup> *Id.* at 43.

<sup>92</sup> *Id.* at 44.

<sup>93</sup> *Id.*

The medical evidence in this case is significantly different than the evidence presented in *Strecker*. In this case, M.H. did not suffer retinal hemorrhages and there was no testimony that the blood on her brain had deteriorated. Dr. Hudson testified that in his opinion, based on a reasonable degree of medical certainty, the injury to M.H. occurred just prior to the onset of symptoms. Appellant offered the report of Dr. Chadwick, indicating that the injury to M.H. occurred within 24 to 48 hours of the onset of symptoms, a time frame not inconsistent with the opinion offered by Dr. Hudson.

Another difference between the facts of the two cases is that there was no evidence that the licensee in *Strecker* had a negative licensing history. The Appellant does have a previous history of correction orders and she also received a conditional license. Moreover, although there is no evidence that Appellant intentionally caused physical injury to any child in her care, two other children in her care suffered broken bones. In one of these cases, the child was injured when he played on equipment in Appellant's home that was not age appropriate.

Finally, Appellant admitted that she lied to her licenser about whether she was conducting her day care in the basement of her home when that area was not licensed for use as part of her day care. This admission reflects adversely on the credibility of Appellant's testimony, including on her testimony that she does not know how M.H. was injured.

For these reasons, the Administrative Law Judge concludes that a preponderance of the evidence supports the Department's determination that Appellant's maltreatment of M.H. caused serious injury and that, based on the maltreatment finding, Appellant's license should be revoked.

**P. M. W.**