OAH 5-1800-37088

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF HUMAN SERVICES

In the Matter of the Appeal of Deana Griffin of the Order of License Revocation of a Child Foster Care License, Maltreatment Determination, and Disqualification	**FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION**

License No. 1098053 (Child Foster Care)

This matter came before Administrative Law Judge Jim Mortenson for an evidentiary hearing on December 2, 2020. The hearing was convened virtually via an internet connection providing visual and audio. The record closed on that date following closing statements.

Kari A. Lindstrom, Assistant Washington County Attorney, appeared on behalf of the Minnesota Department of Human Services (Department) and Washington County. Deana Griffin (Licensee) appeared on her own behalf without counsel.

The Department offered 31 exhibits, and all were admitted into the record. Seven witnesses testified at hearing. The Department called the following individuals to testify: Elizabeth Grover, Washington County Child Protection Social Worker; Katie Olsen, Washington County Licensing Worker; Briana Janssen, University of Minnesota Physicians Nurse Care Coordinator; Brenda Dugas, Fairview Health Systems Nurse Clinician; Jill Johnson Sholtz, Department Office of Inspector General Staff Attorney; and Deana Griffin, Licensee. Liz Ekholm, Guardian ad Litem, testified pursuant to Minn. R. 1400.8605 (2019).

STATEMENT OF THE ISSUES

1. Did Washington County properly determine that Licensee was responsible for maltreatment of a minor by neglect, under Minn. Stat. § 626.556, subds. 2(g), 10e(e), 10e(f) (2018)?

2. Did the Department properly disqualify Licensee from any position allowing direct contact with, or access to, persons served by Department-licensed programs based on serious maltreatment, as defined by Minn. Stat. § 245C.02, subd. 18 (2018)?

3. Did Licensee meet her burden of showing that she does not pose a risk of harm to children served by the program despite her disqualification for serious

maltreatment, under Minn. Stat. § 245C.22, subd. 4 (2018), and is therefore entitled to a set-aside of the disqualification?

4. Did the Department properly revoke Licensee's license based on the maltreatment determination, disqualification, and conclusive licensing violations detailed in the Order of License Revocation dated August 21, 2020, under Minn. Stat. § 245A.07, subds. 1 and 3 (2018)?

SUMMARY OF DETERMINATIONS

1. Washington County's determination that Licensee was responsible for maltreatment of a minor by neglect should be **AFFIRMED**.

2. The Department's disqualification of Licensee from any position allowing direct contact with, or access to, persons served by Department-licensed programs should be **REVERSED**.

3. Because the disqualification based on serious maltreatment was in error, a set-aside is not necessary and is a moot question.

4. The Department's revocation of Licensee's child foster care license should be **AFFIRMED.**

Based upon the evidence in the hearing record, the Administrative Law Judge makes the following:

FINDINGS OF FACT

1. Child A was born October 12, 2018, to Licensee's sister.[1] Child A was born prematurely at 29 weeks.[2] He was hospitalized from birth until January 2019 when he was placed with Licensee.[3]

2. Licensee was also fostering Child A's older sibling who was born July 11, 2017.[4]

3. Licensee's home was in Oakdale, Minnesota.[5] She sometimes stayed in someone else's home, with the foster children, in Minneapolis.[6]

[1] Exhibit (Ex.) 8; Ex. 10; Ex. 11; Testimony (Test.) of Deana Griffin.
[2] Ex. 11 at 9.
[3] Ex. 8-2.
[4] Ex. 8.
[5] Ex. 1 at 1.
[6] Test. of Elizabeth Grover; Ex. 16; Ex. 17.

4. On January 11, 2019, Licensee brought Child A in for a two-month[7] well-child visit with a nurse practitioner.[8] Several issues were noted: possible hip dysplasia; umbilical and inguinal hernias; and patent ductus arteriosus (PDA).[9]

5. A pediatric cardiologist, Dr. Bass, saw Child A for his PDA on January 24, 2019, in Maple Grove.[10] Dr. Bass advised that the PDA would likely need to be closed but that it might be done with a catheter.[11]

6. On February 21, 2019, Dr. Bass saw Child A again.[12] The doctor advised at that time that because the infant was not in heart failure, "we are able to wait and hope that the ductus will become smaller as he gets bigger."[13]

7. On March 29, 2019, Licensee brought Child A to see the nurse practitioner for the child's four-month well-child visit and hernia pre-operation examination.[14] The hernial operation was performed on April 10, 2019.[15]

8. On April 25, 2019, Child A was seen by another pediatric cardiologist, Dr. Lohr.[16] Because Licensee was unhappy with traveling to the clinic in Maple Grove, Dr. Lohr arranged to have care switched to Dr. Sivanandum at a clinic closer to Licensee's home in Oakdale.[17] An appointment was scheduled for April 29, 2019.[18] Dr. Lohr "stressed the importance" of following up with Dr. Sivanandum who would "provide a referral to our interventional cardiologist for closure [of the PDA] or provide ongoing monitoring if appropriate."[19]

9. Despite the arrangements made on April 25 to see Dr. Sivanandum, Licensee instead brought Child A back to see Dr. Bass in Maple Grove on May 9, 2019.[20] Dr. Bass advised the child "should undergo elective closure" of the PDA and that the surgery should occur within the following four weeks.[21]

10. The surgery did not occur, and the next time Licensee brought Child A for a medical appointment was on August 21, 2019, for his 9-month well-child visit.[22] This was after a child protection complaint had been filed on August 15, 2019, alleging

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[7] Child A was only recently released from the neonatal intensive care unit.
[8] Ex. 11 at 6-11.
[9] *Id.* at 6-8.
[10] Ex. 10 at 25-33.
[11] *Id.* at 26.
[12] *Id.* at 23-24.
[13] *Id.* at 24.
[14] Ex. 11 at 12-21.
[15] Ex. 10 at 12.
[16] Ex. 10. at 21-22.
[17] *Id.* at 22.
[18] *Id.*
[19] *Id.*
[20] *Id.* at 12-20.
[21] *Id.* at 13.
[22] Ex. 11 at 22-28.

Licensee had not brought either foster child "in for well-child checks, medical care, or immunizations."[23] The medical provider, Dr. Warnken, noted that Child A's PDA was to be corrected "several weeks ago" and that surgery now needed "to be reestablished, arranged."[24]

11. County Child Protection screened out the August 15 report and forwarded it to Licensing for follow-up.[25] Katie Olsen, a County child foster care licensor, investigated the complaint.[26]

12. During the August investigation, Licensee could not answer basic questions about the children's care such as: when they were last seen for various medical appointments; why she had to reschedule appointments for the children; what some appointments were for, or even the name of one of the children's pediatricians.[27] Licensee did not keep the children's medical records.[28] Licensee could not account for her finances, made up primarily of assistance for the foster children.[29]

13. On August 27, 2019, the County issued a correction order to Licensee, citing her for failing to provide basic medical care for the foster children.[30] Licensee did not challenge the correction order and it is now legally conclusive.[31]

14. Child A was next seen by another pediatric cardiologist, Dr. Hiremath, on October 9, 2019.[32] Surgery for inserting a catheter into Child A's heart to correct his PDA was scheduled for the following week on October 17, 2019, but Licensee did not bring Child A to the appointment.[33]

15. The missed appointment on October 17, 2019, resulted in another complaint being filed.[34] Following a joint child protection and licensing investigation, another correction order was issued on November 7, 2019, addressing sleeping arrangements and a change in household (Licensee and the children were staying more frequently in Minneapolis with other relatives).[35]

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[23] Ex. 13.
[24] Ex. 11 at 22.
[25] Ex. 13.
[26] Test. of Katie Olsen; Ex. 14.
[27] Test. of K. Olsen; Ex. 14.
[28] Ex. 14 at 1; Test. of K. Olsen; Test. of D. Griffin. Similarly, during her testimony, Licensee could not recount many basic facts about when, where, whether, or how she brought Child A to appointments. This, as well as many of the facts that follow, demonstrates not merely a lack of preparation for hearing by Licensee but possibly a cognitive issue which, while not determinative, supports the outcome of this matter.
[29] Ex. 14-3; Test. of K. Olsen.
[30] Ex. 15.
[31] Test. of K. Olsen.
[32] Ex. 10 at 5-11.
[33] Ex. 3; *see also* Test. of D. Griffin (Licensee testified that she was "not sure" if she brought Child A to the October 17 appointment for surgery).
[34] *Id.*
[35] Ex. 17; Ex. 18; Test. of E. Grover; Test. of K. Olsen.

16. Child A's heart surgery was rescheduled for November 14, 2019 and occurred on that date.[36]

17. Child A was to be seen for a post-operative visit on November 20, 2019.[37] The purpose of the visit was to assess the effectiveness of the catheter and ensure there were no complications.[38] Licensee did not bring Child A to the appointment and could not explain why she did not.[39]

18. The post-operative appointment was rescheduled to November 27, 2019.[40]

19. Licensee brought Child A to the November 27, 2019 post-operative appointment. After Child A's echocardiogram, while waiting for the child to be seen in radiology for an x-ray, Licensee became ill and went to the bathroom.[41] When Licensee returned, she had lost her composure and was not functioning well.[42] Her body language, communication, and irrational behavior resembled someone intoxicated.[43]

20. Dr. Hiremath came to speak to Licensee about Child A's condition.[44] The catheter had dislodged from the child's heart and was now in his lung.[45] It was unknown when this occurred.[46] Dr. Hiremath explained to Licensee that Child A needed to be admitted for emergency surgery to correct the catheter.[47]

21. Licensee could not answer simple questions about Child A, such as when he last ate, what was in his bottle, or who was an emergency contact.[48] Licensee stated that she was "not ready" for Child A to be admitted to the hospital.[49] As the doctor and a nurse, Brianna Janssen, discussed the situation with Licensee, Licensee said she had to leave and did so, driving herself to her sister's home.[50] Licensee called the hospital about two hours later to say that she left because she had a stomach ache.[51]

22. Later that day, November 27, Child A's grandmother (Licensee's mother) came to the hospital to attend to Child A.[52] Another complaint was also filed with the County that day.[53]

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[36] Test. of E. Grover; Ex. 3 at 7, 9; Ex. 19 at 3.
[37] Ex. 3 at 9; Test. of Brenda Dugas.
[38] Test. of B. Dugas; Ex. 3 at 14.
[39] Ex. 3 at 11; Test. of B. Dugas; Test. of D. Griffin.
[40] Test. of B. Dugas.
[41] Ex. 3 at 11, 13, 14.
[42] Test. of Brianna Janssen; Test. of D. Griffin; Ex. 3 at11, 13.
[43] Test. of B. Janssen; Ex. 3 at 11, 13.
[44] Ex. 3 at 14.
[45] *Id.* at 12.
[46] *Id.* at 12, 14.
[47] *Id.* at 14.
[48] *Id.*
[49] *Id.*
[50] *Id.*; Test. of D. Griffin.
[51] Ex. 3 at 14.
[52] *Id.*
[53] Ex. 2 at 4-6.

23. While Dr. Hiremath wanted the emergency surgery performed on Child A immediately, the surgery had to wait until medical personnel could be sure it was safe to anesthetize Child A by managing his food intake.[54] The surgery was conducted two days later, on November 29, 2019, and Child A was discharged and placed with another maternal aunt, along with his older sibling, on December 1, 2019.[55]

24. On December 20, 2019, the County notified Licensee that it had determined that she neglected Child A and was, therefore, responsible for maltreatment of the child.[56] The County listed the following reasons for its determination:

- 2 missed well-child visits;
- Failure to set up a surgical procedure when recommended;
- Missing an appointment for a surgical procedure on October 17, 2019;[57]
- Missing the follow-up visit for surgery on November 20, 2019; and
- Inability to provide information to hospital staff to enable emergency medical care on November 27, 2019.[58]

25. On January 10, 2020, Licensee asked the County to reconsider the maltreatment determination.[59] On March 17, 2020, the County notified Licensee that it was not changing its determination.[60]

26. In the meantime, the Department reviewed the County's maltreatment determination and concluded that the maltreatment was serious.[61] The Department's determination was based on its conclusion that Child A suffered an injury as a result of Licensee's maltreatment which required the care of a physician.[62] According to the Department, all of the County's reasons justified the "serious" classification, but most significant was missing the November 20 follow-up appointment.[63] The Department determined that if Licensee had not missed the appointment, the doctor "may have" prevented the necessity for emergency surgery by discovering the catheter before it

[54] *Id.*; Test. of B. Janssen.
[55] Ex. 3.
[56] Ex. 12.
[57] The letter to Licensee (Ex. 12) states she "rescheduled surgical procedure on 10/18/19." This appears to be a typographical error and misstates the reason for the determination. *Compare* Ex. 3, Ex. 12, and Test. of E. Grover.
[58] Ex. 12.
[59] Ex. 22.
[60] Ex. 24.
[61] Ex. 23; Test. of Jill Johnson Sholtz.
[62] Test. of J. Johnson Sholtz.
[63] *Id.*

dislodged and moved to his lung.[64] As a result, the Department disqualified Licensee from direct contact with persons receiving services from the state, such as foster children.[65]

27. Licensee did not make a timely request for reconsideration of the disqualification.[66] As a result, the Department advised the County to recommend to the Department that the Department revoke Licensee's child foster care license.[67]

28. On April 30, 2020, the County sent its recommendation to revoke Licensee's child foster care license to the Department.[68] The County provided an extensive history of Licensee's care of the two foster children to the Department, and recommended that because Licensee "has a disqualification that has not been set aside and no variance has been granted" her license should be revoked.[69]

29. On July 15, 2020, the Department received a tardy request for reconsideration of Licensee's disqualification from Licensee.[70] On August 21, 2020, the Department determined that its disqualification determination was correct and the maltreatment was serious.[71] The Department stated its position that "[i]f you had not missed the follow-up appointment [to the November 14 surgery], the doctors may have caught the device before it traveled to [Child A's] lungs, saving him from a subsequent invasive emergency procedure."[72] The Department also detailed its analysis of the risk of harm Licensee posed to persons served by Department-licensed programs. It articulated the factors and analysis as follows:

> 1. *The nature, severity, and consequences of the event that led to the disqualification*. The county found that you repeatedly failed to meet the child's medical needs by: (1) missing two of his well-child visits; (2) failing to set up a surgical procedure when recommended; (3) rescheduling a surgical procedure that was originally scheduled for October [17], 2019; (4) missing a follow-up visit after surgery that was scheduled for November 20, 2019; and (5) being unable to provide necessary Information on November 27, 2019, when doctors informed you that the child required urgent medical care. Your actions were very serious.
>
> 2. *Whether there is more than one disqualifying event.* You have one disqualifying event based on serious maltreatment.

[64] *Id.* (Dr. Hiremath told the investigator that although it was unknown when the catheter moved, it was possible the emergency surgery could have been avoided had Child A been seen on November 20. The doctor's rationale to explain this was not recorded by the investigator and the doctor did not testify at hearing.)
[65] Ex. 23.
[66] Ex. 25; Ex. 26; Ex. 27.
[67] Ex. 28.
[68] Ex. 21.
[69] *Id.* at 11.
[70] Ex. 27; Ex. 29.
[71] Ex. 29; Ex. 30.
[72] Ex. 29; Ex. 30.

3. *The age and vulnerability of the victim at the time of the event*. The victim was an 11-month-old child who was born prematurely and suffered from a patent ductus arteriosus ("PDA"), which is a congenital heart defect. He was therefore very vulnerable due to his age, medical issues, and inability to care for himself.

4. *The harm suffered by the victim*. The child had surgery on November 14, 2019, to close the PDA in his heart. At some point the PDA device dislodged and could have caused permanent damage. You missed the follow-up appointment scheduled for November 20, 2019. You then rescheduled the appointment for November 27, 2019. On November 27, 2019, doctors found that the PDA device had dislodged and was situated in his lungs, putting him at risk of permanent injury or death. If you had not missed the follow-up appointment, the doctors may have caught the device before It traveled to his lungs, saving him from a subsequent invasive emergency procedure.

5. *Vulnerability of persons served by the program*. The persons served by the program are children who are very vulnerable due to their age, inability to care for themselves, and (in some cases) physical disabilities. The Commissioner must give preeminent weight to the safety of the program clients over the interests of the disqualified Individual.

6. *The similarity between the victim and persons served by the program*. The child was a foster child in your program and was therefore the same as the program clients.

7. *The time elapsed without a repeat of the same or similar event*. The maltreatment is dated December 20, 2019. Given the recency of the incidents that support the maltreatment determination, as well as the pattern of neglect, you have not yet established a track record showing that you are unlikely to commit a similar act in the future.

8. *Documentation of successful completion by the individual studied of training or rehabilitation pertinent to the event.* You provided no evidence of pertinent training or rehabilitation. Therefore, the Commissioner cannot conclude that you have changed your behavior.

9. *Any other information relevant to reconsideration*. The Commissioner must give special consideration to relative placement. Nevertheless, you were responsible for meeting the foster child's medical needs and you repeatedly failed to do so. The county does

> not recommend that the Commissioner set aside, or grant a variance to, your disqualification.[73]

As a result of its analysis, the Department determined that Licensee's disqualification would not be set aside. Factors 1, 3, 4, 5, 6, 7, 8, and 9 were all determinative.[74]

30. On September 25, 2020, the Department issued an amended Order of License Revocation.[75] The Department concluded:

> Because you are responsible for maltreatment of a child, you are disqualified from any position allowing direct contact with, or access to, persons served by DHS-licensed programs, and due to the serious and chronic nature of the licensing violations and the conditions in the program, which impact the health and safety of children In your care, your license to provide child foster care services is revoked.[76]

31. Any finding of fact more appropriately considered a conclusion of law is adopted as such. Any material fact in the Memorandum not specifically reflected in the Findings of Fact is hereby incorporated into the Findings of Fact.

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

CONCLUSIONS OF LAW

1. The Administrative Law Judge and the Commissioner have jurisdiction over this matter pursuant to Minn. Stat. §§ 14.50, 245A.07, and .08 (2020).

2. It is the duty of the Administrative Law Judge to, among other things, take "notice of the degree to which the agency has . . . (ii) fulfilled all relevant procedural requirements of law or rule . . . ."[77]

3. The Department and County have complied with all relevant procedural requirements of law or rule.

[73] Ex. 29 at 2-3.
[74] *Id.* at 3.
[75] Ex. 31. This document amended a technical provision in the Order that was originally issued on August 21, 2020.
[76] *Id.* at 3.
[77] Minn. Stat. § 14.50.

I. Issue 1

4. When the local welfare agency, here the County, makes a determination about whether maltreatment of a child has occurred, this determination "must be made based on a preponderance of the evidence . . . ."[78] At the hearing, the County must likewise show its determination was accurate by a preponderance of the evidence.[79]

5. Maltreatment by neglect includes the failure by a foster parent to "supply a child with necessary food, clothing, shelter, health, medical, or other care required for the child's physical or mental health when reasonably able to do so."[80]

6. A preponderance of the evidence demonstrates that Licensee neglected Child A when she failed repeatedly to ensure Child A was at scheduled medical appointments, most importantly his post-operative appointment following heart surgery in November 2019.

II. Issue 2

7. "The commissioner shall disqualify an individual who is the subject of a background study from any position allowing direct contact with" a foster child when there has been "substantiated serious or recurring maltreatment of a minor under section 626.556" by the individual.[81]

8. "Serious maltreatment" includes "neglect resulting in serious injury which reasonably requires the care of a physician or advanced practical nurse whether or not" such care "was sought, or abuse resulting in serious injury."[82]

9. The Department's claim that Licensee's neglect of Child A was serious maltreatment is not supported by a preponderance of the evidence. Child A required surgery to correct the catheter that had dislodged from his heart through no commission or omission of Licensee. The evidence fails to show that it is more likely than not that this surgery would have been unnecessary had Licensee brought Child A to the follow-up appointment on November 20, 2019, because it is based on speculation.

10. Because Licensee's neglect of Child A was not serious, as defined by Minn. Stat. § 245C.02, subd. 18(a), her disqualification was not proper.

[78] Minn. Stat. § 626.556, subd. 10e(c) and (e) (2018).
[79] Minn. R. 1400.8608 (2019).
[80] Minn. Stat. § 626.556, subd. 2(g)(1) (2018).
[81] Minn. Stat. §§ 245C.14, subd. 1(a)(3), .15, subd. 4(b)(2) (2018).
[82] Minn. Stat. § 245C.02, subd. 18(a) (2018).

III. Issue 3

11. When an individual has been disqualified under Minn. Stat. § 245C.14, the Commissioner must "make a determination as to the [individual's] immediate risk of harm to persons served by the program" in which the individual is associated.[83] If the individual requests reconsideration, "the commissioner may set aside the disqualification if the commissioner finds that the individual has submitted sufficient information to demonstrate that the individual does not pose a risk of harm to any person served…."[84]

12. Because Licensee's disqualification was not proper, the issue of whether the disqualification should be set aside is moot.[85]

IV. Issue 4

13. The Commissioner may revoke a license when a licensee does not comply with applicable law or rule.[86] "When applying sanctions…, the commissioner shall consider the nature, chronicity, or severity of the violation of law or rule and the effect of the violation on the health, safety, or rights of persons served by the program."[87] At a hearing on a licensing sanction, the Commissioner must show reasonable cause for the sanction.[88]

14. The Commissioner has demonstrated reasonable cause for revocation. Specifically, Licensee had multiple license violations and maltreated Child A by neglect.[89]

15. When the Commissioner demonstrates that reasonable cause existed for a sanction, the burden of proof shifts to the license holder.[90] The license holder must demonstrate by a preponderance of the evidence that she was in full compliance with the laws that the commissioner demonstrated the license holder violated, at the time that the commissioner stated the violations occurred.[91]

16. Licensee has made no showing that she was in compliance with the laws the Commissioner has shown Licensee violated at the time the violations occurred. Therefore, there is no basis to overturn the license revocation.

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[83] Minn. Stat. § 245C.16 (2018).
[84] Minn. Stat. § 245C.22, subd. 4(a) (2018).
[85] If the Commissioner determines to the contrary – that the disqualification was proper – it is noted that Licensee did not submit sufficient information to demonstrate she does not pose a risk of harm foster children.
[86] Minn. Stat. § 245A.07, subds. 1(a), 3(a)(1) (2018).
[87] *Id.* at subd. 1(a).
[88] Minn. Stat. § 245A.08, subd. 3(a).
[89] While the disqualification was also a reason for the revocation, and the disqualification is not valid, the remaining reasons continue to support the determination for revocation.
[90] *Id*.
[91] *Id.*

Based upon the foregoing Findings of Fact and Conclusions of Law, the Administrative Law Judge makes the following:

RECOMMENDATION

It is **RESPECTFULLY RECOMMENDED** the Commissioner find:

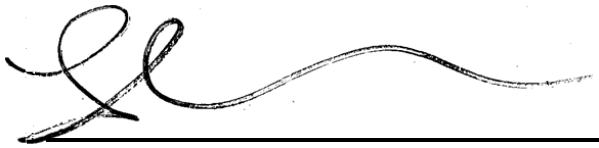
1. Washington County's determination that Licensee is responsible for maltreatment of a minor by neglect under Minn. Stat. § 626.556, subds. 2(g), 10e(e), 10e(f) is **AFFIRMED**.

2. The Department disqualification of Licensee is **REVERSED**.

3. The issue of whether the disqualification should be set aside is **MOOT**.

4. The revocation of Licensee's child foster care license is **AFFIRMED**.

Dated: December 21, 2020



JIM MORTENSON
Administrative Law Judge

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 (2020), 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 64254, St. Paul, MN 55164-0254, (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 (2020). 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 (2020), the Commissioner is required to serve her final decision upon each party and the Administrative Law Judge by first class mail or as otherwise provided by law.

MEMORANDUM

I. Fact Summary

Licensee was the foster parent for two small children, her niece and infant nephew (Child A). Child A had a congenital heart defect (patent ductus arteriosus or PDA) as well as other medical issues.[92] These medical issues put a strain on Licensee's ability to safely and effectively care for the children, particularly her nephew. Licensee missed at least two important appointments for Child A: heart surgery on October 17, 2019, and a post-operative appointment on November 20, 2019.

A report in August led the County to investigate Licensee's care of the children. On August 27, 2019, the County issued a correction order to Licensee, citing her for failing to provide basic medical care for the foster children because it determined that at least two well-child visits had been missed. Given the number of medical appointments Child A required, this correction order was odd given the social worker's lack of concern that there was a problem.[93] Licensee did not challenge the correction order, however, and it is legally conclusive. Another correction order was issued on November 7, 2019, addressing Licensee's living arrangement and the sleeping arrangements for the children. That order was also unchallenged and is deemed conclusive.

More significant, however, are the missed appointments for Child A concerning his heart surgery. Licensee failed to ensure Child A arrived at hospital for surgery to repair the PDA in October, and then missed a post-operative appointment in November. Compounding this, there is no clear explanation for why either appointment was missed. Transportation was arranged to assist Licensee in getting the child to the hospital for the surgery early in the morning on October 17. According to one story Licensee provided, she slept in and missed the provided transportation. The surgery was moved back two hours. Licensee still did not bring the child in because, she told hospital staff, the child had drunk milk that morning and the child was not to eat or drink anything prior to the surgery. According to another story Licensee told, the transportation service went to pick Licensee and Child A up at their home in Oakdale, but Licensee and Child A were staying at a relative's home in Minneapolis. The evidence is in equipoise as to which story, if either, is correct. In any event, Licensee did not ensure her nephew got to his surgery on October 17, 2019.

Then, Licensee did not bring Child A to the November 20 post-operative appointment. She does not know why and never provided any explanation to hospital staff who spoke to her or to social workers. Fortunately, the appointment was rescheduled for November 27, 2020, and the problem with Child A's new heart catheter was discovered. Shortly thereafter it was corrected before the child experienced serious or permanent

[92] Ex. 10; Ex. 11.

[93] *See e.g.* Ex. 17 at 3. "[Child A] only missed his 6-month well-child visit in May; however, he was seen by his cardiologist at that time, who noted no concerns. [As of November 15, 2019] it does not appear that there is a pattern of [Licensee] not meeting [Child A's] medical needs."

harm. Child A and his sibling are now with another aunt who appears capable and willing to care for both children.

II. Arguments

The Department argues that this case is relatively straight-forward. There is a conclusive licensing correction order with regard to Licensee's failure to provide all necessary medical care. Specifically, Licensee missed two well-child visits for Child A. Further, Licensee missed an October 17, 2019, surgery date for Child A, and a November 20, 2019, visit following heart surgery on November 14, 2019. Then, when Licensee was at a rescheduled follow-up visit on November 27, 2019, she was unable to function. This impacted Child A receiving emergency surgery to correct a complication from the November 14 surgery.[94]

According to the Department, there is a preponderance of evidence that neglect occurred. As a result, the maltreatment determination should be upheld.

The Department also argues that the maltreatment was serious. The Department argues that as a result of Licensee's maltreatment, specifically her failure to bring Child A to a post-operative follow-up appointment on November 20, 2019, may have caused a delay in identifying the dislodged and migrating catheter, which then required emergency surgery. Since the maltreatment was serious, disqualification is required under law.

The Department argues that Licensee had the burden to demonstrate that she did not pose a risk of harm to the foster children. Licensee presented no evidence to support her burden of proof on that point, according to the Department.

Finally, the Department argues that revocation is appropriate where a disqualification is not set aside. Further, the nature, chronicity and severity of Licensee's violation is such that revocation is appropriate. Licensee failed to ensure necessary medical care for an infant with significant medical needs due to his premature birth. Missing appointments and failing to follow-through with necessary medical care is of a nature and severity of violation which renders revocation appropriate, according to the Department.

Licensee argues that she was overwhelmed with medical visits due to the medical needs for Child A and that any missed visits did not harm him. She argues that while Child A was cleared for heart surgery in May, the surgery was elective and not required. Licensee argues that once the catheter was implanted in Child A's heart, she was not informed that it could move. The reports about Licensee's parenting did not begin until August 2019.

She also argues that when she missed the November 20 appointment, she could have brought Child A in on November 21, but the hospital staff did not indicate the importance of the appointment. If he needed to be seen sooner, according to License, the

[94] The Department's position is that it is irrelevant as to the reason why Licensee could not function.

medical staff should have said so at the time. On November 27, according to Licensee, Child A had a bottle because she did not know he would require surgery, so it was not her fault he could not have surgery at that time.

Licensee argues that there is not enough evidence to say she is a risk of harm to the children. She argues that she was a blessing to the children and kept them warm, loved, and clothed. Further, she was the only parent they knew and to remove them was a disruption to their lives. Licensee states she has a bright future for herself and the children and that she is a great help to vulnerable people.

III. Analysis

A. The Maltreatment Determination was Correct

Maltreatment of a child under Minnesota law can occur intentionally or unintentionally. When it is unintentional, maltreatment may be by neglect. Maltreatment by neglect can take many forms. One of the forms is a failure to "supply a child with necessary…health, medical, or other care required for the child's physical or mental health when reasonably able to do so."[95]

In this case, the Department found that Licensee neglected Child A when she: missed Child A's six month and nine month well-child visits; failed to schedule the child's heart surgery in May when recommended by the pediatric cardiologist; failed to ensure the child arrived ready for his heart surgery on October 17, 2019; failed to ensure the child arrived for a post-operative visit on November 20, 2019; and was unable to provide information to permit the child to receive emergency surgery on November 27, 2019. The County was required to make the maltreatment determination "based on a preponderance of the evidence…."[96] It made this showing at hearing.

It is true there were multiple medical visits for Child A all throughout his first year of life. He had hernia surgery in April as well as at least one appointment to evaluate his PDA. April was the time for his six-month well-child appointment. It never occurred. This alone is not significant. In May, the pediatric cardiologist recommended surgery occur within a month to address Child A's PDA. Licensee did not do so. She claimed that because it was elective surgery, there was no neglect. She also claimed, without support, that another doctor had said Child A should not have the surgery at that time. In any case, the surgery was not scheduled to occur until October 17, 2019. Had the missed well-child visits and delayed surgery been the only facts in consideration, there may not have been a finding of maltreatment. The remaining findings relied on by the County are much more significant, however.

First, Child A did not go to his surgery on October 17. It was Licensee's responsibility to see he got there. While there are conflicting reasons in the record for why

[95] Minn. Stat. § 626.556, subd. 2(g)(1) (2018).
[96] Minn. Stat. § 626.556, subd. 10e(c) and (e) (2018), Minn. R. 1400.8608 (2019).

she did not have him there, none of those reasons are justification for allowing Child A to miss his surgery.

The surgery was rescheduled and occurred on November 14, 2019. A post-operative follow-up was scheduled for November 20, to ensure there were no complications. Licensee argues that this importance was never stressed to her. She further argues that if it was truly important, the hospital would have had her bring Child A in before November 27. These arguments are without merit and demonstrate that Licensee still does not understand the gravity of Child A's heart condition, the operation to correct it, and Licensee's failure to monitor and ensure he received proper medical care. There is no reason in the record, much less a legitimate reason, that Licensee did not get Child A to the post-operative visit. This omission, on top of the multiple prior omissions, is significant enough to find that maltreatment by neglect occurred.

Finally, while Licensee fumbled her responsibility on November 27, that is irrelevant. At that point, she merely demonstrated that she was unable to effectively care for the child. Much ado was made by the agencies about Licensee's behavior on November 27. However, the only claim resulting from that date was Licensee's inability to say when Child A last ate so that he could – possibly – get surgery right away. The evidence shows she was ill, not under the influence. Even though she was ill, she failed to behave reasonably to ensure Child A was properly cared for. Indeed, throughout the record the evidence is clear that Licensee lacked the competence to care for a medically involved child. In addition to missing important appointments, she failed to keep records necessary for any reasonable parent to follow the goings-on for a child with medical issues. But this was not the articulated basis for any findings by the County. In short, while the missed appointment on November 20 was really the last straw for the County, the events on November 27 simply did not help Licensee.

B. The Disqualification of Licensee was Improper

A foster parent must be disqualified by the Commissioner from being a foster parent (or any position allowing direct contact with persons receiving services from a Department licensed program) when the foster parent has been found to have committed "serious" maltreatment against a minor.[97] "Serious maltreatment" is defined as "neglect resulting in serious injury which reasonably requires the care of a physician…whether or not the care of a physician…was sought…."[98]

The Department concluded that serious maltreatment occurred when Child A's heart catheter migrated to his lung and required surgery. According to the Department, had Licensee not missed the November 20 follow-up appointment, the migrating device could have been detected sooner. The pediatric cardiologist advised the County that while it was unknown when the catheter moved, "the [missed] follow up appointment could have possibly prevented the emergency surgery."[99] Thus, according to the Department,

[97] Minn. Stat. §§ 245C.14, .15, subd. 4(b), 626.556 (2018).
[98] Minn. Stat. § 245C.02, subd. 18 (2018).
[99] Ex. 3 at 14.

missing the November 20 post-operative appointment, which was appropriately determined to be maltreatment by neglect, was serious.

The Department's argument employs a causal fallacy. There may be a correlation between the missed appointment on November 20 and the need for surgery discovered on November 27, but the need for surgery was not proven to have been caused by Licensee's neglect in failing to bring Child A to the November 20 appointment. In other words, the Department did not establish that the neglect resulted in the need for surgery. Thus, the definition of "serious maltreatment" is not met.

Child A had a catheter inserted into his heart to correct his PDA. It was important that the outcome of the surgery be followed to ensure it was effective. If Child A had been seen on November 20 as planned, medical staff may have seen the catheter in place, or it may have moved. Had the device moved, it would not be determined that it was due to Licensee's neglect.[100] Further, if Child A required additional surgery at that time, it is not likely Licensee would have been responsible for the necessity of surgery. Assuming the surgery would have occurred, and the catheter corrected, the matter would be viewed as a typical possible medical outcome and not a serious injury caused by Licensee, even though it is the same outcome that occurred in this case.

Similarly, if Child A had been seen on November 20 and the catheter had not moved, there also would be no consideration of Licensee's responsibility for Child A's condition. More importantly, the cardiologist does not know when the device moved. Thus, it is just as likely that the device moved after November 20 as before that date. If it moved after that date, would it have been timely discovered? It appears just as likely that Child A could have been seriously injured or even have died if he was at the November 20 appointment and the catheter was found to still be in place at that time. This does not excuse Licensee's failure in ensuring Child A was at the appointment. It merely illustrates that Licensee's neglect for failing to bring Child A to his November 20 appointment cannot be said to have, more likely than not, resulted in the need for the follow-up surgery. That need would have arisen in any case, for reasons outside of Licensee's control.

Because Licensee's failure to bring Child A to the November 20 post-operative visit until November 27 is part of a pattern which led to maltreatment by neglect that does not meet the statutory definition of serious, her disqualification was improper.

C. The Question of Whether Licensee's Disqualification Should be Set Aside Because She Posed No Risk of Harm is Moot

"The commissioner may set aside the disqualification if the commissioner finds that the individual has submitted sufficient information to demonstrate that the individual does not pose a risk of harm" to people served by the program.[101] When a licensing sanction "is based on a disqualification for which reconsideration was requested" and not set aside, and the licensee does not have a right to a fair hearing, "the administrative law judge's

[100] There are no allegations or facts that Licensee caused the catheter to dislodge or move.
[101] Minn. Stat. § 245C.22, subd. 4(a) (2020).

review shall include the…sanction and a determination whether the disqualification should be set aside."[102] This determination is made by consideration of "the factors under section 245C.22, subdivision 4, to determine whether the individual poses a risk of harm to any person receiving services from the license holder."[103]

In this case, the disqualification was not proper. Without a disqualification, there is no reason to consider whether there should be a set-aside. A set-aside is not necessary where there is no valid disqualification.

D. Revocation of the License was Proper

The Commissioner may sanction a licensee, including revoking a license, when the licensee "does not comply with applicable law or rule."[104] "When applying sanctions…, the commissioner shall consider the nature, chronicity, or severity of the violation of law or rule and the effect of the violation on the health, safety, or rights of persons served by the program."[105] When the Department shows reasonable cause for revocation, the burden of proof shifts to the licensee to show that all laws allegedly violated were, in fact, complied with at the time the Department alleges they were violated.[106]

The Department revoked the Licensee's child foster care licensee because she neglected Child A by not ensuring he made it to all his necessary or regular medical appointments, she was disqualified, and she had uncontested licensing violations. Child A was an infant born prematurely and had multiple medical needs, including the significant issue with his PDA. Failing to attend to Child A's medical needs by repeatedly missing medical appointments was significant, particularly when one appointment was a post-operative follow-up. Thus, there is reasonable cause for the revocation based on the nature of the violation.

The fact that Licensee's disqualification was not proper has no impact on the Department's determination to revoke the license. The facts underlying the disqualification were the same facts already cited by the Department for the revocation. Thus, relying on the disqualification was merely technical and did not provide additional substance to the rationale for the revocation.

Finally, Licensee admitted to most of the material facts in this case. She provided no evidence to demonstrate she was in compliance with the laws the Department alleged she violated when the violations occurred. Thus, there is no basis to recommend reversal of the sanction in this case.

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[102] Minn. Stat. § 245A.08, subd. 2a(g) (2020).
[103] *Id.*
[104] Minn. Stat. § 245A.07, subd. 1(a).
[105] *Id.*, subd. 3.
[106] Minn. Stat. § 245A.08, subd. 3(a).

IV. Conclusion

A preponderance of the evidence shows the County properly determined Licensee neglected Child A when she missed multiple medical appointments for the child, particularly his post-operative visit scheduled for November 20, 2019. The Department did not properly disqualify Licensee from any position allowing direct contact with, or access to, persons served by Department-licensed programs based on serious maltreatment. A preponderance of the evidence demonstrates that the neglect suffered by Child A did not cause his need for emergency surgery, the injury the Department alleged Licensee's maltreatment caused. Since there was no proper disqualification, there is no need for a set-aside. Finally, a preponderance of the evidence shows that license revocation is appropriate based on the nature of the maltreatment of Child A, given his relatively significant medical needs as an infant. Thus, it is respectfully recommended that the maltreatment determination and license revocation be **AFFIRMED**.

J. R. M.