

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE COMMISSIONER OF HUMAN SERVICES

In the Matter of the Temporary
Immediate Suspension of the Family
Child Care License of Dianne Bolte
To Provide Family Day Care under
Minn. R. pts. 9502.0300 to 9502.0445

**FINDINGS OF FACT, CONCLUSIONS
AND RECOMMENDATION**

The above matter came on for hearing before Administrative Law Judge M. Kevin Snell on December 8, 2006, at the Jackson County Courthouse, 405 Fourth Street, Jackson, Minnesota 56143. The OAH record closed at the end of the hearing on December 8, 2006.

Sherry E. Haley, Assistant Jackson County Attorney, 405 Fourth Street, Jackson, Minnesota 56143, appeared on behalf of the Department of Human Services. Michael P. Kircher, Attorney at Law, 108 Armstrong Blvd. S., P.O. Box 506, St. James, Minnesota 56081, appeared on behalf of the licensee, Dianne Bolte.

NOTICE

This report is a recommendation, not a final decision. The Commissioner of Human Services (Commissioner) will make the final decision after a review of the record and may adopt, reject or modify these Findings of Fact, Conclusions, and Recommendation. Under Minn. Stat. §§ 14.61 and 245A.07, subd. 2a (b), the parties adversely affected have ten (10) calendar days to submit exceptions to this Report and request to present argument to the Commissioner. The record shall close at the end of the ten-day period for submission of exceptions. The Commissioner then has ten (10) working days from the close of the record to issue his final decision. Parties should contact Cal Ludeman, Commissioner of Human Services, Box 64998, St. Paul MN 55155, (651) 431-2907, to learn the procedure for filing exceptions or presenting argument.

Under Minn. Stat. § 14.62, subd. 1, the agency 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.

STATEMENT OF THE ISSUE

Does reasonable cause exist to believe that Dianne failure to comply with applicable law or rule now poses an imminent risk of harm to the health, safety, or rights of children served by her?

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

FINDINGS OF FACT

1. Since November 2005, Dianne Bolte (“Ms. Bolte”) has been licensed to provide family child care services for up to 12 children at her home at 117 Thomas Hill Road, Jackson, Minnesota, Jackson County, Minnesota 56143 (“the home”).¹ Ms. Bolte provides day care services on a 24-hour-a-day basis.² She is assisted by her 20-year-old daughter, Brandi J. Bolte.³

2. As well as other training, Ms. Bolte received the following formal training required by DHS for her license:

- a. Naptime/Sleeping patterns on November 17, 2005;
- b. Sudden Infant Death Syndrome (“SIDS”) and shaken baby on December 8, 2005; and
- c. CPR and first aid in April and May 2006.⁴

3. In May 2006, an Evenflow bassinet was brought into the home by Brandi Bolte, placed in the downstairs bedroom, and was used by Brandi Bolte for her daughter when they would stay overnight in the home.⁵

4. The bassinet remained continuously in essentially the same location in the bedroom through October 24, 2006.⁶

5. The Evenflow bassinet is of sturdy construction, such that a 2-3/8 inch diameter sphere cannot pass through its mesh sides or wooden bottom.⁷ It has a model number on the leg that is difficult to find and a 1-800 number for the manufacturer.⁸ It is

¹ Testimony of Dianne Bolte.

² *Id.*

³ *Id.* and Exhibit 23.

⁴ *Id.*

⁵ Testimony of Dianne Bolte.

⁶ *Id.*

⁷ Exhibits 1-5, testimony of Roslyn Luers and Mary Kelsey

⁸ Testimony of Dianne Bolte and Krystal Preuss.

not listed as an unsafe device on the website of the Consumer Product Safety Commission.⁹

6. Ms. Bolte conducts a monthly crib inspection for all cribs in use for day care children and completes a written report in the first week of each month, and did so the first week of October 2006.¹⁰ Ms. Bolte prepared her November inspection report that included the bassinet for the first time in the first week of November 2006.¹¹

7. JC, an infant born on August 26, 2006,¹² started being cared for by Ms. Bolte on October 9, 2006.¹³

8. According to JC's mother, around September 26, 2006, it had become JC's practice to roll onto his side to sleep, even if he was initially set down on his back to sleep.¹⁴ Dr. Randall testified that, although it was unusual for an infant to roll over at that age, and that favorite positions usually occur when an infant is older, he had no reason to doubt JC's mother.¹⁵

9. The bassinet was used for JC to sleep in beginning on October 9, 2006.¹⁶

10. On October 16, 2006, Ms. Krystal Preuss, Jackson County licenser and case aide, conducted Ms. Bolte's first annual licensing inspection.¹⁷ JC was asleep in the bassinet when Ms. Preuss arrived, and was retrieved by Ms. Bolte when he woke up during the visit.¹⁸

11. Ms. Preuss requested and received the October crib inspection report from Ms. Bolte.¹⁹ Ms. Price visited the bedroom where the bassinet and a crib were present. Although Ms. Preuss stated that she did not remember the bassinet being there and did not look in the bassinet, she does not deny that it was in the bedroom during her walk through inspection.²⁰ She neither commented to Ms. Bolte about the bassinet in any way, nor advised Ms. Bolte about whether or not it was an acceptable infant sleeping arrangement. In fact, Ms. Preuss did not know until October 25, 2006, after researching the issue upon return from the visit with Ms. Bolte that the bassinet failed to meet the crib rule requirements.²¹

12. As a result of this inspection Ms. Preuss issued a routine correction order requiring Ms. Bolte to retag a fire extinguisher, update her provider policy, move items

⁹ *Id.*

¹⁰ Testimony of Dianne Bolte.

¹¹ *Id.*

¹² Exhibit 21.

¹³ Testimony of Dianne Bolte.

¹⁴ *Id.*, and testimony of JC's mother.

¹⁵ Testimony of Dr. Bradley Randall.

¹⁶ Testimony of Dianne Bolte.

¹⁷ Testimony of Dianne Bolte and Krystal Preuss.

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ Testimony of Krystal Preuss.

²¹ Testimony of Dianne Bolte and Krystal Preuss.

further away from the furnace, correct children's communication records, and post an emergency plan.²² Ms. Bolte corrected each item of this order.²³

13. On October 24, 2006, Ms. Bolte was caring for six (6) children in the home, including JC.²⁴ They were:

- a. TCB, a three-year-old boy;²⁵ and
- b. NB, his 17 month old sister;²⁶ and
- c. GW, a 2-½ year old girl;²⁷ and
- d. JW, a two-year-old boy;²⁸ and
- e. D, age unknown, but not an infant and less than 3 years old.²⁹

14. On October 24, 2006, JC's mother dropped him off at Ms. Bolte's home at approximately 7:15 a.m.³⁰ He appeared well and in good health, but had had a runny nose for a couple of days.³¹

15. Because JC was asleep when he arrived, Ms. Bolte placing JC on his back in the bassinet and continued with her normal daily routine with the other children.³²

16. SIDS training recommends that infants be placed on their backs for sleeping.³³ DHS policy is to insist on a physician's statement before permitting placement of infants in any position other than on their back.³⁴

17. While the other children were watching television cartoons in the dining room, Ms. Bolte was in the kitchen preparing a snack for them. She heard JC cry at approximately 8:15 a.m. so she retrieved him from the bassinet and fed him a bottle while she held him as she was sitting in a rocking chair. JC spit up, which was unusual. Ms. Bolte got a baby wipe, cleaned him up and put him in a baby chair.³⁵

²² *Id.*

²³ *Id.*

²⁴ Testimony of Dianne Bolte.

²⁵ Testimony of TCB's and NB's mother.

²⁶ *Id.*

²⁷ Testimony of GW's mother.

²⁸ Exhibit A to the Notice and Order for Hearing.

²⁹ *Id.*

³⁰ Testimony of JC's mother and Dianne Bolte.

³¹ *Id.* and Exhibit 22, page 1 of Dr. Sanchez's consultation report.

³² Testimony of Dianne Bolte.

³³ *Id.* and testimony of Krystal Preuss, Mary Kelsey, and Dr. Randall.

³⁴ Testimony of Mary Kelsey.

³⁵ *Id.*

18. Ms. Bolte then put in a compact disc for the children's usual "music time" in the dining room. Other children wanted to watch Barney on TV and were ready for snack time. JC was "fussy," so Ms. Bolte fed him from another bottle of formula, and he spit up again.³⁶

19. JC fell asleep again after being fed between 9:45 a.m. and 10:00 a.m. and Ms. Bolte put him into the bassinet, but because JC had spit up, she laid him on his side so he would not choke if he spit up again.³⁷

20. The locking gate for the door going into the bedroom where JC was sleeping was not up.³⁸

21. The Bolte home is small.³⁹ From the furthest reaches of the kitchen to the location of the bassinet in the bedroom was at most 35 feet.⁴⁰ The kitchen, dining room and living room are all within hearing of the bedroom where JC was sleeping.⁴¹ The kitchen and living room are not within sight of the bassinet in the bedroom.⁴² Most of the dining room is within sight of the bassinet in the bedroom, with the exception of the spot where one stands to change diapers at the changing table.⁴³

22. After putting JC down to sleep, Ms. Bolte changed the diapers on two other children, ate snacks with the other children in front of the TV in the dining room around 10:00 a.m. and checked in on JC at least once before eventually stepping into the living room and sitting at the computer to do some paperwork.⁴⁴

23. Ms. Bolte heard nothing she considered unusual and heard no crying while she was in the living room.⁴⁵

24. JC, TCB, GW and JW were within hearing but out of Ms. Bolte's sight for less than 13 minutes.⁴⁶

25. Upon returning to the bedroom, Ms. Bolte found JC in the bassinet in the same position on his side, still covered from the waist down, with blood on the mattress sheet from his nose and/or mouth and not breathing.⁴⁷

26. While trying to find a pulse, Ms. Bolte immediately called 911 at 10:13 a.m.⁴⁸

³⁶ *Id.*

³⁷ *Id.*, and Ex. 18.

³⁸ *Id.*, see Ex. 7.

³⁹ Ex. 24 and testimony of: Jackson Chief of Police Andre Schofield, Roslyn Luers and Dianne Bolte.

⁴⁰ Testimony of Jackson Chief of Police Andre Schofield.

⁴¹ Testimony of: Jackson Chief of Police Andre Schofield, Roslyn Luers and Dianne Bolte.

⁴² Ex. 24.

⁴³ *Id.* and testimony of Dianne Bolte and Roslyn Luers

⁴⁴ Testimony of Dianne Bolte, Ex. 18.

⁴⁵ *Id.* and Ex. 20.

⁴⁶ *Id.*

⁴⁷ Testimony of Dianne Bolte.

27. Emergency medical technicians (EMTs) Galen McCarthy and Larry Olsen arrived at the home at 10:15 a.m., took JC from Ms. Bolte's arms and found JC without a heartbeat and not breathing.⁴⁹ JC had no physical signs of trauma.⁵⁰ The EMT's performed CPR on JC immediately upon arrival.⁵¹

28. The EMT's left the home at 10:19 a.m. and transported JC to the Jackson Medical Center, continuing to administer extraordinary measures to JC, and arrived at 10:21 a.m.⁵²

29. JC's heartbeat was restored at the Jackson Medical Center, he was intubated and placed on a respirator. JC had no physical signs of trauma.⁵³ JC was promptly airlifted to Avera McKennan Hospital's Neonatal Intensive Care Unit in Sioux Falls, South Dakota.⁵⁴

30. Later in the morning of the 24th, Ms. Bolte called the police after TCB told her that JW had tipped over the bassinet and he, TCB, had put JC back into the bassinet.⁵⁵

31. Jackson County Deputy Kelly Mitchell, trained in interviewing small children, received permission from TCB's mother and interviewed TCB in the bedroom of the childcare home, at 2:03 p.m. on October 24, 2006. The interview was recorded.⁵⁶ Among other statements, TCB denied playing in the bedroom or jumping on the bed. He then said he was "Watching TV and I got up" and that "JW tipped him over" and "I saw blood" "Blood everywhere." When asked who was in the bedroom, he said, "GW wasn't on the bed." "The baby fell over and I picked him up in the crib." "He tipped over on the tractor." "Blood on his forehead." "I was really careful like this." "He didn't fall down." Then TCB demonstrated for Deputy Mitchell by lifting up a doll and dropping, but not throwing, it into the bassinet about an inch or two. Then TCB said that JC "fell on this car and there was blood" pointing to the multicolored toy tractor seen in Exhibits 1, 2, and 7.⁵⁷

32. There was no physical evidence that the bassinet had been tipped over.⁵⁸ There was no blood on JC's forehead or anywhere on any objects, including the tractor or the carpet, except on the bassinet sheet and mattress.⁵⁹

⁴⁸ *Id.*, Ex. 20 and testimony of Galen McCarthy.

⁴⁹ *Id.*

⁵⁰ Testimony of Galen McCarthy, Ex. 20.

⁵¹ *Id.*

⁵² *Id.*

⁵³ Testimony of Dr. Ronald Kline.

⁵⁴ Ex. A to the Notice and Order for Hearing.

⁵⁵ Testimony of Chief Andre Schofield and Dianne Bolte.

⁵⁶ Ex. 19 and testimony of Deputy Kelly Mitchell and TCB's mother.

⁵⁷ Ex. 19.

⁵⁸ Testimony of Chief Andre Schofield, Deputy Kelly Mitchell and Dianne Bolte.

⁵⁹ *Id.*, see Exs. 33, 4, 8-17.

33. TCB's mother did not believe that TCB, weighing 41 lbs., was capable of lifting JC, weighing 12 lbs., up above his shoulders and placing him into the bassinet. TCB has trouble handling a doll, and to the best of his mother's knowledge had never held a baby, even though he has seen his older sister do so.⁶⁰

34. Extraordinary measures continued for JC at Avera McKennan for two more days, but he died on October 26, 2006.⁶¹

35. When JC was cared for and examined at Avera McKennan, there was no evidence found of inborn error of metabolism, viruses, bacteria, gross trauma, shaken baby syndrome, or historical signs of abuse.⁶² JC's differential diagnosis at Avera McKennan was "sepsis, near sudden infant death syndrome, inborn error of metabolism, and seizure disorder."⁶³ JC's death was diagnosed as a SIDS death by exclusion, although an inborn error of metabolism and suffocation were both possibilities.⁶⁴

36. Dr. Bradley Randall conducted JC's autopsy on October 27, 2006. Dr. Randall determined that JC's bloody nose itself did not contribute to his death. Dr. Randall was unable to determine the cause of death because the autopsy only showed changes associated with a heart stopping and breathing stopping. There was no evidence of natural or traumatic disease.⁶⁵ "No significant underlying natural disease was seen to explain the initial cardiac arrest and subsequent death. The absence of significant pathologic changes sufficient to represent a cause of death represents a component of the diagnostic criteria for the sudden infant death syndrome (SIDS)."⁶⁶ None of the actual physical evidence was inconsistent with a SIDS death.⁶⁷

37. Infant SIDS deaths can occur at any time, even when the child is being held by a parent.⁶⁸

38. The bassinet was removed from the home into a storage shed on October 25, 2006, and inspected by Krystal Preuss on November 1, 2006.⁶⁹

39. JC's mother was happy with the care he received from Ms. Bolte.⁷⁰

40. The mother of TCB, NB, and HB believes her children receive good care from Ms. Bolte and would like to continue to use her as a care provider.⁷¹

⁶⁰ *Id.*

⁶¹ Exs. 21 and 22.

⁶² Testimony of Dr. Robert Johnson.

⁶³ Ex. 22, at page 4 of 4 of Dr. Johnson's October 25, 2006, report at 1330 hours, and Dr. Sanchez report of October 24, 2006.

⁶⁴ *Id.*

⁶⁵ Testimony of Dr. Bradley Randall.

⁶⁶ Ex. 21, page 1.

⁶⁷ Testimony of Dr. Bradley Randall.

⁶⁸ *Id.*

⁶⁹ Testimony of Dianne Bolte and Krystal Preuss.

⁷⁰ Testimony of JC's mother.

41. The mother of GW and WW hopes to continue to use Ms. Bolte as her children's' care provider in the future.⁷²

Procedural Findings

42. On October 24, 2006, Roslyn Luers, Licensed Social Worker for Jackson County Department of Human Services, opened a file after the agency received a report that a child had been removed from a day care in an emergency situation.⁷³

43. On October 25, 2006, Ms. Luers went to Ms. Bolte's home, met with her about the incident, and examined the entire home.⁷⁴

44. After returning from her visit with Ms. Bolte, Ms. Luers consulted with different social workers, including: Krystal Preuss; the team leader; the head director; a supervisor; and individuals at the Department of Human Services ("DHS"). By the end of the day on the 25th, the County made a preliminary maltreatment determination of neglect based on lack of supervision and a recommendation to DHS that a temporary immediate suspension be issued while the investigation continued.⁷⁵

45. The reasons for the decision were "because a lot of things were unclear," possible law enforcement report that the baby tipped out, possible lack of supervision during JC's sleeping time, whether the sleeping arrangement was allowable and documented, and whether Ms. Bolte was following SIDS training.⁷⁶

46. Jackson County recommended that the Department issue an order of immediate suspension, pursuant to Minn. Stat. § 245A.07, suspending Ms. Bolte's license to provide day care pending a full investigation and decision on what, if any, final sanctions should be imposed on Ms. Bolte's child care license.⁷⁷

47. The Department issued an order of temporary immediate suspension on October 26, 2006, and it was served on Ms. Bolte that same day.⁷⁸

48. Ms. Bolte filed a timely appeal from the order of temporary immediate suspension and requested an appeal hearing pursuant to Minn. Stat. § 245A.07, subd. 2a.⁷⁹

49. On October 30, 2006, Jerry Kerber, Director, Division of Licensing, Minnesota Department of Human Services, executed a Notice of and Order for Hearing scheduling a contested case hearing on November 28, 2006.⁸⁰

⁷¹ Testimony of the mother of TCB, NB, and HB (a five year old at school on Oct. 24, 2006).

⁷² Testimony of the mother of GW and WW.

⁷³ Testimony of Roslyn Luers.

⁷⁴ *Id.* and testimony of Dianne Bolte.

⁷⁵ Testimony of Roslyn Luers and Krystal Preuss.

⁷⁶ *Id.*

⁷⁷ *Id.*

⁷⁸ Ex. A to the Notice and Order for Hearing.

⁷⁹ Notice and Order for Hearing.

50. On November 13, 2006, the Administrative Law Judge issued a Protective Order, which was served upon the parties by mail on November 14, 2006.

51. On November 15, 2006, Jackson County recommended to the Department that the final sanction in this case be a one-year conditional license with ten (10) specific conditions agreed upon by Ms. Bolte.⁸¹

52. On November 21, 2006, by letter to the Administrative Law Judge, Ms. Bolte requested a continuance and waived all applicable time requirements for a prompt hearing.⁸²

53. On November 21, 2006, the parties, by telephone conference with the undersigned Administrative Law Judge, agreed to conduct the hearing on December 8, 2006.

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

CONCLUSIONS

1. The Commissioner of Human Services and the Administrative Law Judge have jurisdiction in this matter pursuant to Minn. Stat. §§ 14.50 and 245A.07, subds 2 and 2a.

2. The Department of Human Services gave proper and timely notice of the hearing in this matter.

3. The Department has complied with all relevant substantive and procedural requirements of law and rule.

4. Pursuant to Minn. Stat. § 245A.07, subd. 2., in order to sustain a temporary immediate suspension, the Department must show that reasonable cause exists to believe that Ms. Bolte's failure to comply with applicable law or rule poses a current imminent risk of harm to the health, safety, or rights of persons served by Ms. Bolte.

5. "Imminent danger" means a child or vulnerable adult is threatened with immediate and present abuse or neglect that is life threatening or likely to result in abandonment, sexual abuse, or serious physical injury."⁸³

6. Neglect of a child constitutes maltreatment.⁸⁴ Neglect is defined to mean:

⁸⁰ *Id.*

⁸¹ Testimony of Krystal Preuss.

⁸² November 21, 2006, letter signed by Mr. Kircher, Ms. Bolte (also signed by Assistant County Attorney Haley, noting lack of objection to the continuance).

⁸³ Minn. Rule pt. 9543.1010, subp. 8

⁸⁴ Minn. Stat. § 626.556, Subd. 2., (c) (3).

failure to provide for necessary supervision or child care arrangements appropriate for a child after considering factors as the child's age, mental ability, physical condition, length of absence, or environment, when the child is unable to care for the child's own basic needs or safety, or the basic needs or safety of another child in their care;⁸⁵

7. "Supervision" is defined as:

"a caregiver being within sight or hearing of an infant, toddler, or preschooler at all times so that the caregiver is capable of intervening to protect the health and safety of the child. For the school age child, it means a caregiver being available for assistance and care so that the child's health and safety is protected."⁸⁶

8. At the time it issued the temporary immediate suspension order, the Department determined that it had reasonable cause to believe that Ms. Bolte failed:

- a. to have an approved crib for infant JC when he was sleeping; and
- b. to adequately supervise JC, TCB, JW, and GW by keeping them within her sight or hearing but by being in the living room where it would be unlikely that she would be capable of rapidly intervening to protect the health and safety of JC, TCB, JW and GW;⁸⁷ and
- c. to place JC on his back in the bassinet, in contradiction of the recommendations presented in the Sudden Infant Death Syndrome (SIDS) training she had received.

9. Minnesota Rules part 9502.0425, Subp. 9 provides:

Infant and newborn sleeping space. There must be a safe, comfortable sleeping space for each infant and newborn. A crib, portable crib, or playpen with waterproof mattress or pad must be provided for each infant or newborn in care. The equipment must be of safe and sturdy construction that conforms to volume 16, parts 1508 to 1508.7 and parts 1509 to 1509.9 of the Code of Federal Regulations, its successor, **or have a bar or rail pattern such that a 2-3/8 inch diameter sphere cannot pass through.** Playpens with mesh sidings must not be used for the care or sleeping of infants or newborns. (emphasis added).

10. The Department had reasonable cause to believe that Ms. Bolte's bassinet failed to meet the requirement for acceptable sleeping space. It neither met the federal requirements nor had a bar or rail pattern.

⁸⁵ Minn. Stat. § 626.556, Subd. 2., (f) (2).

⁸⁶ Minn. Rule 9502.0315, Subp. 29a.

⁸⁷ Minn. Rule 9502.0365, subp. 5, and as defined in Minn. Rule 9502.0315, Subp. 29a.

11. When sitting at the living room computer, Ms. Bolte violated the supervision requirement of Minn. Rule 9502.0315, Subp. 29a. because she was in a location where it would be unlikely that she would be capable hearing activities in the bedroom over the sound of the television, her attention was on the computer, and other children were between her and the bedroom where JC was sleeping. The Department had reasonable cause to believe that Ms. Bolte failed to provide adequate supervision.

12. Minn. Stat. § 245A.144 requires license holders such as Ms. Bolte to ensure that persons assisting in the care of infants receive training on reducing the risk of Sudden Infant Death Syndrome. Ms. Bolte received the required training.⁸⁸ Although she followed its recommendations on October 24, 2006, when she put JC into the bassinet the first time, she failed to follow the recommendations the second time when she placed him on his side so he wouldn't choke.⁸⁹

13. Minn. Rules, part 9502.0415, subp. 1(B) requires that daycare activities provide for the physical, intellectual, emotional and social development of the child. The environment must facilitate the implementation of the activities. Activities must be appropriate to the developmental stage and age of the child.

14. The Department failed to show that Minn. Rules part 9502.0415, subp. 1(B) can be reasonably interpreted to require childcare providers to strictly follow SIDS sleeping recommendations. The Department has not cited, nor has the Administrative Law Judge located, any other rule that would require compliance with the SIDS recommendations as a condition of licensure.

15. The Department failed to show that it had reasonable cause to believe that Ms. Bolte violated any rule when she placed JC in the bassinet on his side.

16. TCB's statements about the other child tipping over the bassinet with JC in it, there being "blood everywhere" and on the toy tractor, and his putting JC back into an upright bassinet is inherently improbable and not credible.⁹⁰

17. At the time of the hearing Ms. Bolte: understood the SIDS infant sleeping recommendations, had agreed to be retrained on SIDS, had agreed to improve supervision by agreeing to use a baby monitor and keep the gate up between the dining room and bedroom when infants are sleeping in the bedroom, and had agreed to use only approved cribs.⁹¹ Neither DHS nor the county presented evidence that Ms. Bolte presented a current, imminent risk of harm to children at the time of the hearing.

18. At the hearing, Ms. Preuss concurred that Ms. Bolte demonstrated that she is willing to take all necessary measures to prevent any future similar situations.⁹²

⁸⁸ Finding of Fact 2.

⁸⁹ Finding of Fact 19.

⁹⁰ Findings of Fact 5, 23, 25, 32, and 35-37, and also see, *State v. Florence*, 306 Minn. 442, 239 N.W.2d 892, 902 (1976).

⁹¹ Testimony of Ms. Preuss that Ms. Bolte agreed to the 10 conditions proposed by the County to DHS.

⁹² *Id.*

Ms. Bolte agreed to: only work 12 hours in any 24 hour period; utilize a 2nd adult helper if over 6 children were in her care; retake the SIDS training; use a baby monitor; have no rule violations; be granted no variances; use a gate between the sleeping area and the play area; and move the toys from the sleeping room to the play room (dining room).⁹³

19. The Department has failed to demonstrate at the time of the hearing that reasonable cause now exists to continue the immediate suspension of Ms. Bolte's day care license.

20. These Conclusions are reached for the reasons set forth in the Memorandum below, which is hereby incorporated by reference into these Conclusions.

21. The Administrative Law Judge adopts as Conclusions any Findings that are more appropriately described as Conclusions, and as Findings any Conclusions that are more appropriately described as Findings.

Based upon these Conclusions, and for the reasons explained in the accompanying Memorandum, the Administrative Law Judge makes the following:

RECOMMENDATION

Based upon these Conclusions, the Administrative Law Judge recommends to the Commissioner of Human Services that:

The temporary immediate suspension of the family day care license of Ms. Dianne Bolte be immediately withdrawn and rescinded.

Dated: December 21, 2006

s/M. Kevin Snell

M. Kevin Snell
Administrative Law Judge

Reported: Tape recorded (seven (7) tapes); no transcript prepared.

⁹³ Testimony of Ms. Preuss that Ms. Bolte agreed to the 10 conditions proposed by the County to DHS and Findings of Fact 2, 12, 38-41, and 51. There were two conditions not specified by Ms. Preuss in her testimony.

MEMORANDUM

At this stage, the Commissioner of Human Services is not required to prove that this incident actually occurred. Instead, the Commissioner must only prove that there is reasonable cause to believe that the health, safety or rights of persons in the Ms. Bolte' care are at imminent risk. This is a modest standard, intended to insure that vulnerable children are protected until there can be a full hearing and final determination on the underlying charges.

During an expedited hearing regarding a temporary immediate suspension, the Commissioner must only present reliable oral testimony and/or reliable documentary evidence in support of a finding of reasonable cause. The statute governing family day care does not specifically define what is meant by reasonable cause to suspend a license. The Department is entitled to rely on hearsay evidence linking the license holder (or a person present during the hours that children are in care) to an act that puts children at risk of imminent harm. The term "imminent harm" also is not defined in the statute or day care rules, but other rules adopted by the Commissioner define the term "imminent danger" to encompass situations in which a child is threatened with immediate and present abuse or neglect that is life-threatening or likely to result in abandonment, sexual abuse, or serious physical injury. Although this definition is not binding, it is instructive.

The Administrative Law Judge, at this stage of the process, is not required to assess the relative credibility of conflicting testimony, but rather is to determine whether there is enough evidence to maintain the suspension. However, where the Licensee submits evidence that makes the alleged violation "inherently improbable" or "seemingly impossible under the circumstances," evidence offered by the Licensee will overcome a probable cause determination.⁹⁴

All parties agree that any SIDS death is a tragedy. The Legislature recognized that SIDS deaths can be reduced (but not totally avoided) if persons caring for infants receive appropriate training. It therefore required that all persons in licensed facilities who are caring for infants must receive appropriate training. Ms. Bolte had the required training. She followed the training by putting JC on his back the first time she put him down to sleep on October 24, 2006. Although JC was extremely young to be rolling over, and favorite sleeping positions such as JC's usually occur after infants get older, there is no reason to doubt his mother.⁹⁵

The Department claims that by not placing JC in the recommended sleeping position Ms. Bolte violated a rule that requires age-appropriate activities at the licensed facility. The Administrative Law Judge does not believe that either the plain wording or any reasonable interpretation of that rule covers the actions that occurred in this case. If there is a need to enforce a requirement that babies be placed on their backs unless the

⁹⁴ *Id.* 239 N.W. 2d at 903 & n. 24; see also *In Re the Temporary Immediate Suspension of the License of Darcy Sime to Provide Family Child Care*, OAH Docket No. 58-1800-14955-2 (2002), at 7-8.

⁹⁵ Testimony of Dr. Bradley Randall.

provider has documentation from a physician, then there needs to be a specific rule that imposes that requirement, so that the Department has a necessary tool and licensors and licensees have adequate notice of enforcement expectations.⁹⁶

Ms. Bolte argued that, because Ms. Preuss was in the home and in the bedroom on October 16, 2006, and said nothing about the bassinet, she should not be cited for the infant sleeping situation violation. It is unlikely that Ms. Bolte would be able to show that the elements of estoppel existed.⁹⁷

Even when the evidence offered by the Commissioner is reviewed in light of the modest “reasonable cause” standard of proof, it is not adequate to establish reasonable cause to continue the temporary immediate suspension. The original suspension was issued when the cause of JC’s death was unknown, based upon TCB’s statements, there was reason to believe Ms. Bolte failed to provide adequate supervision, all thereby posing a continuing risk of harm and requiring an immediate temporary suspension of the child care license.

However, at the time of the hearing, the Department failed to show that Ms. Bolte presented any such risk. It was determined that JC’s death was attributable to SIDS, TCB’s statements that JC and the bassinet tipped over were determined to be not credible, and Ms Bolte had agreed to the necessary conditions to assure the safety of the children in her care. Thus, at the time of the hearing there was no reasonable cause to believe that Ms. Bolte presented an imminent risk of harm to the health, safety, or rights of the children served by her.

M.K.S.

⁹⁶ *In the Matter of the Revocation of the License of Jennie Musty to Provide Family Child Care*, OAH Docket No. 6-1800-15386-2 (2003).

⁹⁷ See, *Ridgewood Dev’t and In re Westling Manufacturing*, 442 N.W. 2d 328, 332 (Minn. App. 1989) and also *Brown v. Dept of Public Welfare*, 368 N.W.2d 906 (Minn. 1985).