

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 Beverly Greenagel To Provide
Family Day Care

**FINDINGS OF FACT,
CONCLUSIONS AND
RECOMMENDATION**

The above matter came on for hearing before Administrative Law Judge M. Kevin Snell on October 11 and 12, 2011, at the Dakota County Judicial Center, 1560 Highway 55, Hastings, Minnesota 55033. The hearing record closed upon the receipt of the parties' closing briefs on October 18, 2011.

Margaret M. Horsch, Assistant Dakota County Attorney, appeared at the hearing as attorney for the Minnesota Department of Human Services (the "Department") and the Dakota County Social Services Department. Marc G. Kurzman, Kurzman Grant, appeared on behalf of Beverly Greenagel, the Licensee.

STATEMENT OF THE ISSUE

The issue is whether or not there is reasonable cause to believe that the health, safety or rights of children in Ms. Greenagel's care are at imminent risk of harm at this time.

The Administrative Law Judge concludes that there is reasonable cause to believe that children in Licensee's care are at imminent risk of harm.

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

FINDINGS OF FACT

1. Ms. Greenagel (Licensee) has been licensed to provide family child care services since 1976, when family child care was first required to be licensed. She provided unlicensed child care from January of 1973 until she became licensed. She has recently provided licensed family child care in her home in Eagan, Minnesota, under a C2 license until August 19, 2011, when her license was suspended.¹

¹ Testimony of Beverly Greenagel and Joan Visnovec, Dakota County Social Services Child Care Licensor; Exhibit 11.

2. Licensee's home contains four levels, three of which are licensed for child care. The fourth, lowest, level is unlicensed. There is a sunroom on the main level, adjacent to the kitchen, which exits into the back yard.²

3. Infants sleep in three separate rooms: Licensee's office on the main level that contains one crib; an upper level bedroom that contains one crib; and a lower level bedroom that contains two cribs and a pack 'n play crib. Licensee does not utilize baby monitors in infant sleeping areas. The home contains an inoperable intercom system. Licensee is willing to repair the intercom system if her license is reinstated and the cost is \$500.00 or less.³

4. Licensee has received a number of certificates of recognition from local child care provider associations, the Mayor of Eagan and two Governors of the State of Minnesota.⁴ None of these awards or certificates were endorsed or issued by the Department of Human Services, which is the State agency that licenses family child care providers and enforces the minimum licensure standards set forth in statute and rule.⁵

5. Licensee has the confidence and support of 15 current and former day care parents, and one former day care child. They universally believe that children are and were safe and happy in Licensee's care. The current day care parents are anxious to return their children to Licensee's care.⁶

Licensee's Licensing History

6. On April 6, 1984, Licensee was caring for a number of children in excess of her licensed capacity. She had too many infants and too many toddlers in care. Licensee then acknowledged that further violations of capacity could affect her license.⁷

7. On June 13, 1984, the County received a complaint from a parent that Licensee is "never there." The report goes on to state:

that she has hired a 16 year old girl to substitute for her. The parent stated that Bev leaves to shop, play racquetball, get her hair done, etc. and that 9 out of 11 times that she has called Bev during the day the helper was there alone with the children. The parent said that she liked Bev and her home, but feels that Bev should be providing the day care not teen-age substitutes.⁸

8. As a result of another complaint, an unannounced licensing visit on January 26, 1994 revealed that Licensee was over her licensed C1 capacity when she

² Ex. 113; Test. of B. Greenagel, J. Visnovec, and K.W.

³ Test. of B. Greenagel, J. Visnovec.

⁴ Exs. 102 – 109; Test. of B. Greenagel.

⁵ Test. of J. Visnovec.

⁶ Exs. 115 - 128.

⁷ *Id.*; Ex. 20.

⁸ *Id.*

was caring for 10 children with nine under school age. Three of the children were under 30 months. Licensee was reminded that she needed two adults to care for that number of children. The complaint also stated that Licensee had an enrollment of 17 children. The Licensor determined that Licensee had 19 children enrolled, but scheduled for different times of day.⁹

9. During an April 18, 2007, annual licensing visit, Licensee was reminded by the Licensor to: "Make sure infants slept in required sleep space – crib." During that visit Licensee listed one of her two goals for the following year as "Declutter."¹⁰

10. On February, 25 2002, Licensee signed an acknowledgment on a form titled, "**Lowering the Risk of Sudden Infant Death Syndrome**," stating that she had read the following requirements and took a class on reducing SIDS:

- **Place babies on their backs to sleep, both at nighttime and at naptime.** Research shows that fewer babies die of SIDS when they sleep on their backs.
- **Place babies on a firm mattress in an approved crib.** Don't put babies to sleep on soft mattresses, sofas, sofa cushions, waterbeds, sheepskins, or other soft surfaces.
- **Remove all fluffy and loose bedding from the sleep area.** Make sure you take all pillows, quilts, stuffed toys, and other soft items out of the crib.
- **Make sure babies' head and face stay uncovered during sleep.** Keep babies' mouths and noses clear of blankets and other coverings during sleep. Use sleep clothing with no other covering over the baby. If you do use a blanket or another covering, make sure the baby's feet are at the bottom of the crib, the blanket no higher than the baby's chest, and the blanket tucked in around the crib mattress.¹¹

11. Licensee sent an undated, hand written note to the Licensor stating, in relevant part:

It worked great to put a large plain sheet folder (sp) over crib mattress & pin it snugly in the back. [Infant] doesn't even try to get it off anymore – I probably will go back to a fitted sheet but I think I'll stick with this 'til he's about 18 mos. & then try a fitted sheet.¹²

12. Two of the reasons for the sleeping requirements for infants are to ensure their mouths and noses are not up against any soft object that would prevent them from

⁹ Ex. 21; Test. of J. Visnovec.

¹⁰ Ex. 18; Test. of J. Visnovec.

¹¹ Ex. 14.

¹² Ex. 19; Test. of J. Visnovec.

breathing fresh air, and to prevent them from rebreathing the CO₂ that they exhale.¹³ Rebreathing prevents oxygen from entering the lungs and can contribute to suffocation.¹⁴

13. Licensee is unfamiliar with positional asphyxia. Licensee knows that it is improper to place an infant for sleeping on or with a blanket. She also knows that infants may not be left unattended on their stomach because they cannot hold their head up and it would be difficult for them to breathe.¹⁵

14. A 12-year-old child, K.W., has been cared for by Licensee since she was two years old. When K.W. was in Licensee's care, Licensee would usually be caring for 12 to 13 children without additional caregivers. Occasionally, two of Licensee's teenage grandchildren would help care for the day care children.¹⁶

15. K.W. began caring for other children, including infants, when she was ten years old in the summer of 2009. She also helped Licensee care for children in the summers of 2010 and 2011.¹⁷ K.W. has received no training for prevention of SIDS or shaken baby training, either from Licensee or formal, certified training elsewhere.¹⁸

16. A.E. (a toddler) and D.B. (an infant) commonly slept with loose blankets in their cribs.¹⁹

Licensee's Initial Care of the Infant D.A.

17. Licensee began caring for the infant D.A. (date of birth April 30, 2011) some time in early August 2011. Prior to D.A.'s parents selecting Licensee as D.A.'s day care provider, Licensee told D.A.'s parents that she only cares for eight children. Licensee cared for D.A. on six days prior to August 18, 2011.²⁰

18. D.A. was not capable of either rolling over without help or lifting up his head.²¹

19. Licensee always placed D.A. on the floor to sleep because there were not enough cribs.²² D.A.'s parents did not give consent to this sleeping arrangement for D.A.²³

¹³ Test. of J. Visnovec.

¹⁴ *Id.*; Test. of Detective Paul Maier, Eagan Police Department, and Mac Ableidinger, a trained Emergency Medical Technician.

¹⁵ Ex. 9 at 5; Test. of B. Greenagel.

¹⁶ Ex. 7 at pg. 23, 31.

¹⁷ *Id.*; Test. of K.W.

¹⁸ *Id.*

¹⁹ Ex. 9 at 8.

²⁰ Ex. 7 at 33; Test. of B. Greenagel, Stephanie Ableidinger and M. Ableidinger.

²¹ *Id.*; Test. of B. Greenagel.

²² Ex. 7 at 32.

²³ Test. of S. Ableidinger and M. Ableidinger.

August 18, 2011 – Water Wars

20. Licensee provides an annual summer event called “Water Wars” in her backyard. The 2011 event was held on August 18, 2011. The event involves water balloons that are fired from mechanical catapults among two teams of children. All current and some former day care children, excluding infants, are invited and allowed to participate. The event runs throughout the day.²⁴ The equipment involved, consisting of pipes and wooden planks, is rented from a former day care parent.²⁵

21. During the week prior to August 8, 2011, Licensee called K.W. and asked her if she wanted to come and play in Water Wars on August 18, 2011 and help take care of the day care children. K.W. agreed.²⁶ Licensee knew she would have many children in care and chose not to seek additional adult caregivers, although she knew she could and should have planned for additional adult caregivers.²⁷ One qualified adult caregiver is regularly scheduled to arrive at 3:00 p.m.²⁸

22. K.W. was dropped off by her mother at 9:00 a.m. Licensee immediately asked her to look after the children in the living room: two toddlers; six preschoolers; and one school age child.²⁹

23. After watching the other children for 10-15 minutes, K.W. went downstairs and played Wii with three school age boys: E.K., T.F., and L.T. Then she went outside to help set up for Water Wars. At that time two infants, D.B. and G.G., were in an upstairs bedroom. K.W. played Water Wars with other children for approximately an hour in the morning, before lunch. After lunch cleanup, K.W. again went downstairs and played Nintendo with two school age boys, E.K. and M.T.³⁰

24. D.A.’s mother dropped him off with Licensee at 12:30 p.m.³¹ At approximately 1:00 p.m., K.W. returned upstairs and saw Licensee with D.A. in the living room. This was the first time she had seen D.A.³²

25. At this time on August 18, 2011, Licensee was responsible for the care of the following 18 children in her home:

Infants (6 weeks up to 12 months):

D. A. (3 months)

D. B. (6 months)

G. G. (11 months)

Toddlers (12 months up to 24 months):

A. E. (13 months)

E. D. (19 months)

²⁴ Test. of B. Greenagel and K.W.

²⁵ Ex. 7 at 18.

²⁶ Ex. 7 at 23; Test. of K.W. and B. Greenagel.

²⁷ Test. of G. Greenagel.

²⁸ Ex. 7 at 23, 31; Test. of K.W.

²⁹ *Id.*

³⁰ *Id.*

³¹ Test. of S. Abliedinger.

³² Ex. 7 at 23; Test. of K.W.

Preschoolers (24 months up to the age of being eligible to enter Kindergarten within 4 months):
B. S. (3 years)
J. L. (3 years)
I. D. (3 years)
G. G. (3 years)
B. W. (4 years)
V. E. (4 years)
L. D. (4 years)
M. K. (4 years)³³

School Aged:
C. D. (5 years)
E. C. (7 years)
E. K. (7 years)
L. T. (7 years)
M. T. (8 years)

26. Licensee asked K.W. if she would feed D.A. . K.W. agreed and fed D.A. a bottle at approximately 1:00 p.m. K.W. then changed his diaper and placed him on his back on a floor mat of the sunroom to play. K.W.'s mother then called her on her cell phone at 1:15 p.m.³⁴

27. K.W. went back downstairs and played Nintendo for a while, then went outside to play in Water Wars, and then went back downstairs and played Nintendo until snack time at approximately 2:00 p.m.³⁵

28. At times during Water Wars both Licensee and K.W. were outside filling water balloons.³⁶

29. D.A. was still on the floor mat and starting to doze off at approximately 1:50 p.m. Licensee picked him up and took D.A. downstairs to the sleeping room between 2:00 and 2:10 p.m. When she arrived in the sleeping room, J.L. woke up and crawled out of his crib on his own and went upstairs. Licensee folded a flannel blanket eight times and placed it on the floor. Licensee then placed D.A. on the blanket to sleep and went back upstairs to watch from the kitchen as children played Water Wars outside.³⁷

30. After snack time K.W. again went back downstairs and played Nintendo in the room adjacent to the infant sleeping room.³⁸

31. K.W. quit playing Nintendo at approximately 3:20 p.m. As she walked past the infant sleeping room she looked in and saw D.A. laying face down on the blanket on the floor.³⁹

³³ Exs. 3 at 17 and 22; 4 at 9; 5; 6 at 21, 26, 27, 32, 36, and 37.

³⁴ Ex. 7 at 23, 31; Test. of K.W. and B. Greenagel.

³⁵ Ex. 7 at 24; Test. of K.W.

³⁶ Test. of K.W. and B. Greenagel.

³⁷ Test. of B. Greenagel; Exs. 110 - 113.

³⁸ Ex. 7 at 24; Test. of K.W.; Ex. 113.

³⁹ Ex. 7 at 1; Test. of K.W.; Exs. 110 -113.

32. K.W. saw that D.A.'s face was imbedded in the blanket, which had been folded several times. Her first thought was that D.A. wouldn't be able to breathe. When K.W. rolled D.A. on his side, his face was purple and there was blood dripping from his mouth onto the blanket. D.A. was cold to the touch and his face was purple. K.W. concluded that D.A. was dead.⁴⁰

33. K.W. screamed and Licensee ran downstairs. Licensee told K.W. to go upstairs and call 911, which K.W. did immediately at 3:21 p.m. Upon hearing the dispatcher ask: "Police and fire, how can I help you?" K. W. stated: "Oh, um, there's a baby dead. Um."⁴¹

34. Licensee picked up D.A., placed D.A. on her left shoulder, then folded the blanket that D.A. had been sleeping on over once with one hand, and then placed it on a pile of blankets in the sleeping room.⁴² Then Licensee ran upstairs, took the telephone away from K.W., and stated, "No it's not dead." The Licensee then stated, "Well, he rolled over and bumped his head."⁴³

35. The Dispatcher then directed Licensee to perform CPR and directed her specifically how to perform CPR on D.A.⁴⁴

36. At 3:26 p.m., the police arrived and took over CPR from Licensee. D.A. was cool to their touch, his skin was white and his toes and fingers were dark blue. D.A. had no pulse. Emergency medical technicians took over the CPR from the officers. All efforts to revive D.A. failed and he was pronounced dead at 3:53 p.m.⁴⁵

37. After the police arrived, Licensee directed K.W. to go back down to the sleeping room and take E.D. out of her crib.⁴⁶

38. Eight-year-old M.T. and seven-year-old E.K. also saw the blood on the blanket next to D.A. when it was on the floor.⁴⁷

39. The flannel blanket on which D.A. was found bears blood stain patterns consistent with two nostrils and a mouth that would match up where D.A.'s face had been in the blanket when he purged blood from his hemorrhaging lungs.⁴⁸

40. A law enforcement investigation was commenced immediately. Licensee was interviewed, during which time she made a number of false statements to the detectives and the coroner and presented them with an inaccurate reenactment of the events of that day, including:

⁴⁰ Exs. 1, 9 at 8, 110 - 113; Test. of K.W.

⁴¹ Exs. 2, 7 at 1; Test. of K.W. and B. Greenagel.

⁴² Test. of B. Greenagel.

⁴³ *Id.*

⁴⁴ Ex. 2.

⁴⁵ Ex. 7 at 13, 18.

⁴⁶ Test. of K.W.

⁴⁷ Exs. 8 at 1, 7 at 34; Test. of K.W.

⁴⁸ Exs. 1, 7 at pg. 17; Test. of P. Maier and M. Ableidinger.

- a. that she had placed D.A. down to sleep, on his back, in a crib at 2:45 p.m.; and
- b. that she checked on D.A., who was still on his back in the crib at 3:00 p.m.; and
- c. that she found D.A. on his back in the same place she had placed him, not breathing, at 3:30 p.m.; and
- d. that D.A. had bumped his head; and
- e. that infants and toddlers never slept with blankets in their cribs; and
- f. that she placed a blanket and a bottle in E.D.'s crib when E.D. was not sleeping in it, after she picked up D.A.; and
- g. that the red stains on the left front shoulder of her blouse were makeup; and
- h. that she was watching 14 children that day; and
- i. that she was watching 15 children that day.⁴⁹

41. A few minutes later, when Licensee and K.W. were outside of the home as law enforcement personnel were working inside, Licensee told K.W. not to talk about blood. Before K.W. left with her mother and Detective Schultz, Licensee moved between K.W. and the detective and whispered in K.W.'s ear words to the effect of: "Remember, I put D.A. down to nap in a crib." K.W. understood this to mean that Licensee wanted K.W. to lie about what had actually happened.⁵⁰

42. Licensee's false statements to law enforcement were discovered during its first interview with K.W. Licensee eventually admitted to law enforcement she had lied. She lied because she had panicked.⁵¹

43. On August 18, 2011, Licensee's kitchen counters contained a significant number of toxins that were accessible to children, including: sunscreen; soaps; lotions; Mary Kay products; vitamins; magnesium cell salts; and prescription medicine.⁵²

Procedural Findings

44. There are ongoing law enforcement and County Child Protection investigations of D.A.'s death.

⁴⁹ Exs. 7 at 15, 19, 20, 22, 25; Test. of D. Schultz and P. Maier; Ex. 17.

⁵⁰ Test. of K.W., B. Greenagel, and D. Schultz.

⁵¹ Id.; Exs. 3, 4, 6 and 7.

⁵² Exs. 12 – 13A; Test. of J. Visnovec and B. Greenagel.

45. On August 19, 2011 Dakota County Social Services Department recommended to the Department that Ms. Greenagel's family child care license be immediately suspended.⁵³

46. On August 19, 2011, the Department issued an Order of Temporary Immediate Suspension of Licensee's family child care license.⁵⁴

47. Licensee filed a timely appeal from the Order of Temporary Immediate Suspension and requested an appeal hearing pursuant to Minn. Stat. § 245A.07, subd. 2a.⁵⁵

48. On August 24, 2011, the Department executed a Notice of and Order for Hearing, scheduling a contested case hearing for September 26, 2011.⁵⁶ The hearing was continued due discovery issues related to the ongoing criminal investigation related to the events that are the subject of this proceeding. The parties agreed to continue the hearing to October 11, 2011.

49. On September 20, 2011, the Administrative Law Judge issued an Order for Hearing and Protective Order, which was served upon the parties that day.

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.⁵⁷

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. The purpose of family child care licensure statutes and rules is to protect the care, health, and safety of children.⁵⁸

⁵³ Test. of J. Visnovec.

⁵⁴ Ex. 11.

⁵⁵ Notice and Order for Hearing.

⁵⁶ *Id.*

⁵⁷ Minnesota Statutes are cited to the 2010 Edition.

⁵⁸ Minn. Stat. § 245A.07, subd. 1; Minn. R. 9502.0325.

Temporary Immediate Suspension Standards and Reasonable Cause

5. 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 Licensee'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 her.

6. At hearing, the burden of proof is on the Department to show that reasonable cause exists to believe that the license holder's actions or failure to comply with applicable law or rule, the actions of another, or the conditions in the program, pose an imminent risk of harm to the health, safety, or rights of persons served by the program.⁵⁹

7. "Reasonable cause" for the purpose of a temporary immediate suspension means:

there exist specific articulable facts or circumstances which provide the commissioner with a reasonable suspicion that there is an imminent risk of harm to the health, safety, or rights of persons served by the program.⁶⁰

Family Child Care Law and Rules Alleged to Have Been Violated

8. Minn. R. 9502.0365 regarding **LICENSED CAPACITY, CHILD/ADULT RATIOS, AGE DISTRIBUTION RESTRICTIONS** provides in relevant part as follows:

Subpart 1. **Capacity limits.** Family day care and group family day care providers shall comply with part 9502.0367, which limits the total number of children and the number of preschoolers, toddlers, and infants who may be in care at any one time, **and provides for the number of adults who are required to be present.** (emphasis added) . . .

Subp. 4. **Helpers.** A helper may be used in place of a second adult caregiver when there is no more than one infant or toddler present.

Subp. 5. **Supervision and use of substitutes.** A licensed provider must be the primary provider of care in the residence. Children in care must be supervised by a caregiver. The use of a substitute caregiver must be limited to a cumulative total of not more than 30 days in any 12-month period.⁶¹

9. Minn. R. 9502.0367 regarding child/adult ratios and age distribution restrictions provides that a C2 Group Family Day Care license permits one adult to have 12 total children, only ten of whom may be under school age, and of the total children under school age, a combined total of no more than two shall be infants and toddlers.

⁵⁹ *Id.*

⁶⁰ *Id.*

⁶¹ Minnesota Rules are cited to the 2011 Edition.

10. Minn. R. 9502.0315 provides the following **Definitions**, in applicable part:

Subpart 1. **Applicability.** As used in parts 9502.0315 to 9502.0445, the following terms have the meanings given them.

Subp. 2. **Adult.** "Adult" means a person at least 18 years of age.

Subp. 6. **Caregiver.** "Caregiver" means the provider, substitute, helper, or another adult giving care in the residence.

Subp. 14. **Helper.** "Helper" means a person at least 13 years of age and less than 18 years of age who assists the provider with the care of children.

Subp. 29. **Substitute.** 'Substitute' means an adult at least 18 years of age who assumes the responsibility of the provider as specified in part 9502.0365, subpart 5.

11. Minn. Stat. § 245A.50 regarding **FAMILY CHILD CARE TRAINING REQUIREMENTS** provides in relevant part as follows:

Subd. 5. **Sudden infant death syndrome and shaken baby syndrome training.** (a) License holders must document that before staff persons, caregivers, and helpers assist in the care of infants, they are instructed on the standards in section 245A.1435 and receive training on reducing the risk of sudden infant death syndrome. In addition, license holders must document that before staff persons, caregivers, and helpers assist in the care of infants and children under school age, they receive training on reducing the risk of shaken baby syndrome. The training in this subdivision may be provided as initial training under subdivision 1 or ongoing annual training under subdivision 7. . . .

12. Minn. Stat. § 245A.1435 providing for **REDUCTION OF RISK OF SUDDEN INFANT DEATH SYNDROME IN LICENSED PROGRAMS**, provides as follows:

(a) When a license holder is placing an infant to sleep, the license holder must place the infant on the infant's back, unless the license holder has documentation from the infant's parent directing an alternative sleeping position for the infant. The parent directive must be on a form approved by the commissioner and must include a statement that the parent or legal guardian has read the information provided by the Minnesota Sudden Infant Death Center, related to the risk of SIDS and the importance of placing an infant or child on its back to sleep to reduce the risk of SIDS.

(b) The license holder must place the infant in a crib directly on a firm mattress with a fitted crib sheet that fits tightly on the mattress and overlaps the mattress so it cannot be dislodged by pulling on the corner of the sheet. The license holder must not place pillows, quilts, comforters, sheepskin, pillow-like stuffed toys, or other soft products in the crib with the infant. The requirements of this section apply to license holders serving infants up to and including 12 months of age. Licensed child care providers must meet the crib requirements under section 245A.146.

13. Minn. R. 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)

14. Supervision is defined to mean:

‘Supervision’ means 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.⁶²

Violations Found

15. The Department has demonstrated that there was reasonable cause to believe that Licensee was over capacity as follows the afternoon of August 18, 2011, and therefore in violation of Minn. R. 9502.0365 and Minn. R. 9502.0367 during that time:

- a. Six total children in excess of licensed capacity; and
- b. Three toddlers in excess of licensed capacity; and
- c. Two infants in excess of licensed capacity; and
- d. Three children under school age in excess of licensed capacity; and
- e. Six school age children in excess of licensed capacity.

⁶² Minn. R. 9502.0315, subp. 29a.

16. The Department has demonstrated that there was reasonable cause to believe that Licensee utilized 12-year-old child K.W., as a caregiver in violation of Minn. Stat. § 245A.50, Minn. R. 9502.0315, and Minn. R. 9502.0365, subs. 1, 4 and 5.

17. The Department has demonstrated that there was reasonable cause to believe that Licensee violated Minn. Stat. § 245A.50 by utilizing the child K.W. as a caregiver who had not taken SIDS and shaken baby training prior to caring for infants.

18. The Department has demonstrated that there was reasonable cause to believe that Licensee failed to intervene to protect the health and safety of D.A. when she left D.A. unattended for over an hour, in violation of Minn. R. 9502.0315, subp. 29a.

19. Licensee violated Minn. Stat. § 245A.1435 and Minn. R. 9502.0425, subp. 9, by placing the infant D.A. on the floor, on a blanket to sleep, and failing to provide an approved crib for the infant D.A.

Reasonable Cause Conclusions

20. When the Order was issued on August 19, 2011, there were specific articulable facts and circumstances indicating law and rule violations that provided the commissioner with a reasonable suspicion to believe that all of the children in Ms. Greenagel's care were at imminent risk of harm.

21. At the hearing, Licensee failed to express any commitment that she will take necessary measures to prevent any future similar situations as occurred in August 18, 2011. The evidence is sufficient for a reasonable, prudent person to conclude that there is a reasonable suspicion that Licensee presents a current, imminent risk of harm to children.

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

23. 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:

- 1) The temporary immediate suspension of the family day care license of Beverly Greenagel be affirmed; and

- 2) The September 20, 2011 Protective Order of the Administrative Law Judge shall remain in effect.

Dated: November 1, 2011

s/M. Kevin Snell

M. KEVIN SNELL
Administrative Law Judge

Reported: Digitally recorded; no transcript prepared.

NOTICES

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 Lucinda Jesson, 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.

MEMORANDUM

Burden of Proof

At this stage, the Department of Human Services is not required to prove by a preponderance of the evidence that actions by individuals or violations actually occurred. Instead, at this stage, during an expedited hearing regarding a temporary immediate suspension, the Department must only present reliable oral testimony and/or reliable documentary evidence in support of a finding of reasonable cause. This is a very modest standard, intended to insure that vulnerable children are protected until there can be a full hearing and final determination on any violations of law or rule.

Permitted Evidence

The Department and the Administrative Law Judge are entitled to rely on hearsay evidence linking the conditions in the program or the license holder (or any person present during the hours that children are in care) to an act that puts children at risk of imminent harm. In this case, there was little conflicting testimony or statements regarding the material facts.

Parent Support

The evidence from daycare parents, all who have direct knowledge about Licensee and the daycare she provides, describe Licensee in terms that are consistently favorable. The Minnesota Court of Appeals has determined that such evidence is relevant and desirable in TIS cases.⁶³ However, their affidavits can be given slight weight in this proceeding because they show little knowledge of the relevant facts.

Admissibility of Licensee's Polygraph Examination

Licensee made a number of pretrial motions, all of which were resolved by agreement of the parties, except for her motion to admit the results of a polygraph exam and allow testimony of the test administrator, Mr. Barry R. Woodgate. After arguments of counsel, for the reasons stated below, the ALJ denied the motion, did not admit Licensee's polygraph examination into evidence in this proceeding, and did not allow Mr. Woodgate to testify. There is no evidence in the record to suggest that Mr. Woodgate is qualified to administer and interpret polygraph examinations.

Licensee argued that use of polygraph tests is routine by the County in probation/parole violations and by other government agencies elsewhere. However, Licensee offered no supporting authority for this assertion. The County argues that Licensee's position is without merit and that it does not offer polygraph results in any court for any purpose. The County offered no affidavits or testimony for its position either. However, the ALJ concluded that neither was necessary to rule on the admissibility of Licensee's polygraph test results and whether Mr. Woodgate would be allowed to testify.

The only routine and acceptable official use of polygraphs of which the ALJ is aware is during the treatment of sex offenders within the Minnesota Sex Offender Treatment Program (SOTP) under the jurisdiction of the Department of Corrections. See, of Minn. R. 2965.0160, subp. 2 and Minn. R. 2965.0160, subp. 2. Those rules have specific and extensive standards for the use of polygraphs within SOTP and the qualifications of the examiners. However, SOTP use of polygraphs does not mean that polygraph results are or would be admitted into evidence in sex offenders' appeals of their risk level assignments under Minn. Stat. § 244.052, subd. 6.

⁶³ *In Re Strecker*, 777 N.W.2d 41, 46 (Minn. App. 2010).

Licensee argues that *Duluth v. Duluth Police Local*, 2005 WL 1620352 (Minn. App. 2005) stands for the proposition that polygraph results should be admissible in administrative proceedings because they were admitted by an arbitrator in that case. In that case, both parties engaged polygraph experts. The Court of Appeals concluded that arbitration proceedings are not subject to the same evidentiary rules as courts of law. By definition, arbitrators are permitted to conduct their proceedings with very few rules.

The rules of evidence in administrative proceedings are governed by Minn. Stat. § 14.60, and, in these proceedings, Minn. R. 1400.8607, subp. 1, which provides in relevant part as follows: “Evidence which is incompetent, irrelevant, immaterial, or unduly repetitious shall be excluded.”

Administrative proceedings are not arbitrations. The Administrative Law Judge concludes that polygraph results are incompetent evidence in administrative proceedings. That is and has been the rule of law in criminal and civil courts since the Supreme Court’s holding in *State v. Kolander*, 52, N.W. 2d 459 (Minn. 1952). See also, *State v. Michaeloff*, 324 N.W.2d 926 (1982) and *State v. Anderson*, 379 N.W.2d 70 (Minn. 1985). There is still insufficient evidence of the reliability of polygraph tests for them to be allowed into evidence in civil and administrative matters without agreement of all parties. *State v. Opsahl*, 513 N.W.2d 249 (1994).

Violations of Law and Rule Presenting an “Imminent Risk of Harm”

The evidence in the record suggests a long history of intentional overcapacity violations, improper use of unqualified children as helpers, use of improper sleeping arrangements for infants, and supervision failures.⁶⁴ Licensee’s significant violations on August 18, 2011, including overcapacity, supervision failure, use of an unqualified and untrained child as a helper, and use of unsafe and unlawful sleeping arrangements for the infant D.A. were knowing and intentional.

Improper Sleeping Arrangements for D.A. and Other Infants

The law requires that an infant be put to sleep on its back in a crib directly on a firm mattress with a crib sheet that fits tightly on the mattress and overlaps the mattress so it cannot be dislodged by pulling on the corner of the sheet and that there are no soft products in the crib with the infant.⁶⁵ Licensee testified that she knows exactly what the required sleeping arrangements are for infants. In spite of this fact, the record suggests that she has used improper sleeping arrangements for infants on a routine basis since 1984. Licensee also testified that it is her regular practice to place infants on the floor on blankets to sleep upstairs in the changing room. Her reason that she wants to get to know the infants’ patterns does not supercede the rule on sleeping arrangements. Licensee violated the infant sleeping rules when putting D.A. down to sleep on

⁶⁴ Findings 6 – 9.

⁶⁵ Conclusions 12, 13 and 19.

August 18, 2011. There is no evidence in the record to suggest that a lawful crib could not be, or has now been, placed in the sunroom.

Later, Licensee placed D.A. to sleep on the floor, on a loose blanket that had been folded several times. This was done in spite of the fact that an empty crib was available. Licensee either did not want to take the time to provide D.A. with a clean sheet in the available crib, or she knew she couldn't supervise the other 17 children properly while she was changing a crib sheet. This behavior suggests that Licensee considered her convenience more important than following the law and rules.

Failure of Required Supervision

After she had placed D.A. on a folded blanket on the floor, Licensee left D.A. unattended and unchecked for over an hour. If the 12-year-old child had not looked into the sleeping room, seen D.A. face down on the blanket, instantly determined that he wouldn't be able to breath in that position, one can only speculate how long D.A. would have been left there by Licensee. Even if Licensee was able to hear a crying infant from her location on the upper level of the home, she did not hear D.A. suffocating in the blanket. The record is clear that Licensee was in no position to come to D.A.'s aid while he was sleeping on the floor downstairs and Licensee was watching from the kitchen upstairs as the older children engaged in a water balloon fight. The seriousness of this violation is magnified by the overcapacity violations.

Lack of Immediate Use of CPR on D.A.

Licensee waited to perform CPR on D.A. until she received specific instructions from the 911 operator. Although Licensee is apparently trained in the use of CPR, she failed to immediately attempt to revive D.A. It is reasonable to expect all trained caregivers to react immediately to an emergency requiring the use of CPR. The fact that Licensee did not do so suggests that she is unable to react properly in an emergency situation. At the hearing, Licensee made no indication that she would or could react differently in the future.

Current Conditions of the Program

In addition, key factors were unchanged at the time of the hearing: Licensee's lack of explanation for failure to have qualified helpers or adult substitutes on a day that she knew would be filled with activity and children, both inside and outside; lack of testimony or documentary evidence that the clutter of toxic materials in the kitchen that is accessible to children had been removed; lack of evidence that Licensee knows how to perform CPR on an infant; lack of commitment to utilize infant monitors in the future; and Licensee's lack of an articulated commitment to follow all applicable child care laws, regulations, and orders.

When asked specifically what assurance she could give that she would follow all applicable laws and rules "to a T" in the future, Licensee stated that the regulators could

just drop by any time and look at her records. A reasonable person would not consider that an unqualified commitment to follow all laws and rules that apply to child safety.

Conclusion

Due to the combination of the foregoing factors, the Administrative Law Judge concludes that the Department has established that reasonable cause exists to believe that any children in Licensee's care are at imminent risk of harm. This matter is a tragic example of why the laws and rules on licensed capacity, supervision, use of qualified helpers and substitutes, and infant sleeping arrangements are in place. Actual harm is not required in these matters. The evidence indicates that there is a quantifiable, continuing risk of imminent harm to children in Licensee's care.

M.K.S.