FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION


Debra A. Groehler, Assistant Olmstead County Attorney, appeared on behalf of the Minnesota Department of Human Services (Department). Eric Anderson, Anderson Defense, appeared on behalf of Molly Rieke-Hofschulte (Licensee).

STATEMENT OF THE ISSUES

Should the temporary immediate suspension of Licensee's family child care license remain in effect pending issuance of a final order as to any licensing sanction?

SUMMARY OF RECOMMENDATION

At the time the Department issued the Order of Temporary Immediate Suspension (Order) there were specific articulable facts giving the Department reason to suspect that Licensee presented an imminent risk of harm to the health, safety, or rights of children served by the program. However, notwithstanding the reasonableness of the Department's initial action, the record here shows that Licensee does not pose an imminent risk of harm to the health, safety, or rights of children served by the program. For this reason, the Administrative Law Judge recommends that the Commissioner of the Department of Human Services (Commissioner) RESCIND the Order.

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

I. Licensee's Background

1. Licensee is licensed to provide family child care and operated a daycare in her home in Rochester, Minnesota. Licensee first obtained her license in August 1999, and opened her daycare upon receiving her license.

2. Licensee is a member of Governor Mark Dayton’s Early Learning Council and has served on the Dover-Eyota school board.

3. Licensee is current with her statutorily-required Sudden Unexpected Infant Death and Abusive Head Trauma (SUID/AHT) training and also recently assisted in providing training to 300 people on SUID.

4. Between 1999 and 2009, Olmsted County Social Services (County) issued Licensee correction orders for violations related to having fire extinguishers checked and tagged, maintaining updated forms such as immunization forms for children in her childcare, turning down hot water and covering outlets.

5. On March 26, 2002, Licensee was issued a correction order for not being current on her SUID training. Licensee had until April 26, 2002 to take the training, and she completed the training on April 2, 2002.


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1 Ex. 235; Testimony (Test.) of Molly Rieke-Hofschulte.
2 Ex. 202 (Family child care license).
3 Test. of M. Rieke-Hofschulte.
4 Test. of M. Rieke-Hofschulte.
5 Test. of M. Rieke-Hofschulte.
6 Ex. 204 (July 17, 2000 Correction Order); Ex. 205 (July 25, 2001 Correction Order); Ex. 210 (July 12, 2005 Correction Order).
7 Ex. 204 (July 17, 2000 Correction Order); Ex. 205 (July 25, 2001 Correction Order); Ex. 208 (January 18, 2005 Correction Order); Ex. 210 (July 12, 2005 Correction Order).
8 Ex. 205 (July 25, 2001 Correction Order).
9 Ex. 210 (July 12, 2005 Correction Order).
10 Ex. 206 (March 26, 2002 Correction Order). At the time, and in the March 26, 2002 Correction Order, SUID was referred to as Sudden Infant Death Syndrome (SIDS).
11 Id.
12 Ex. 216 (Correction Order); Ex. 217 (Correction Order); Ex. 220 (April 30, 2012 Correction Order); Ex. 239 (July 11, 2017 Correction Order).
7. The County investigated complaints filed by parents on August 31, 2004 and April 22, 2014, and determined the complaints were unsubstantiated. The County determined that the second complaint was false.

8. On May 6, 2013 and on June 1, 2014, Licensee submitted training information to the County indicating that she was current on her SUIDS training.

II. The Infant’s Death

9. On October 27, 2017, the County received a report that a three-month-old infant, B.S., had died in Licensee’s daycare.

10. B.S. had been attending Licensee’s childcare for just two weeks. He attended intermittently, according to his mother’s work schedule. He attended two days his first week at Licensee’s childcare. October 27, 2017, was his fifth day in the childcare home. Since he first attended Licensee’s childcare, B.S. had a cold and his mother told Licensee that B.S. would only sleep in a car seat or in a swing. Licensee explained that she could not sleep an infant in that manner. However, for the first four days he attended, she placed a rolled-up towel under the mattress of a pack-and-play in order to provide a little elevation for B.S. On the day B.S. died, Licensee had not placed a towel under the mattress.

11. On October 27, 2017, at 5:15 a.m., B.S.’s mother dropped him off at Licensee’s home. When she dropped him off, B.S.’s mother told Licensee that Licensee would be happy because for the past two nights B.S.’s parents had been laying him flat to sleep, his cold was clearing up, and Licensee could lay him flat to sleep.

12. B.S. had a normal morning at the childcare. Licensee gave him a bottle of formula at approximately 6:15 a.m. He took about 2 ounces of formula and spit up much of it. This was common for B.S. during the few days Licensee had cared for him.

13. On October 27, 2017, B.S. enjoyed watching the other children. Before Licensee prepared lunch for the other children, Licensee sang and danced with B.S. as she carried him to a pack-and-play for a nap. The pack-and-play is in her bedroom, located down a short hallway from the kitchen. Licensee placed B.S. on his back at one side of the pack-and-play so that he could feel the mesh side with his arm. Licensee believed that, since B.S. had been sleeping in a car seat or swing, feeling the side
would be comforting for him. She set a timer on the kitchen stove for twenty minutes to remind herself to check on B.S., and then she fed the other children lunch. After the children finished lunch and were getting ready to start other activities, the timer went off and Licensee went to check on B.S.\textsuperscript{23}

14. When Licensee reached B.S. he was lying as she left him except that his head was turned to the right. She noticed that his skin was dry instead of sweaty, as it had been every other day Licensee tried to wake B.S. and he would not wake. Licensee knew she needed help and knew she needed to start CPR. She picked B.S. up and went to the kitchen get her phone. Licensee began to give B.S. CPR and dialed 911. The local ambulance station is two blocks from her home and a sheriff lives across the street. Both arrived quickly, as did many other medical personal and law enforcement.\textsuperscript{24}

15. Deputy Sheriff Detective Chad Winters of the Olmsted County Sheriff's Office responded to the 911 report of an infant death at Licensee's home. Detective Winters arrived at the home and turned on his body camera prior to entering.\textsuperscript{25}

16. When Detective Winters entered the home, an ambulance crew was attempting to revive B.S. Other daycare children were still present in the home. Also present was Sargent Carmack of the Olmsted County Sheriff's Office who identified Licensee for Detective Winters.\textsuperscript{26}

17. Detective Winters interviewed Licensee at her kitchen table.\textsuperscript{27}

18. While Detective Winters was interviewing Licensee, the death investigator from the medical examiner's officer, John Lehman, came to Licensee's home and asked Licensee to reenact what happened. Licensee demonstrated how she placed B.S. when putting him down for a nap and what position she found him in when she returned. Mr. Lehman gave Licensee a hard plastic doll to represent B.S. for the reenactment. Detective Winters filmed the reenactment with his body camera.\textsuperscript{28} Still photographs of the doll's placement were also taken.\textsuperscript{29} Others in the room during the reenactment were Detective Hanson, who took photos, and Sergeant Long, who supervised the investigation.\textsuperscript{30}

19. During the reenactment, Licensee placed the doll all the way to the right of a pack-and-play. When Licensee first placed the doll into the crib, Detective Winters perceived it to be at about a 45 degree angle with its spine at the edge of the pack-and-play. Licensee did not think that her initial placement looked right and so she

\begin{itemize}
\item \textsuperscript{23} Test. of M. Rieke-Hofschulte.
\item \textsuperscript{24} Id.
\item \textsuperscript{25} Test. of C. Winters.
\item \textsuperscript{26} Id.
\item \textsuperscript{27} Test. of C. Winters; Test. of M. Rieke-Hofschulte.
\item \textsuperscript{28} Test. of C. Winters; Test. of M. Rieke-Hofschulte; Ex. 253 (SUID Reporting Form).
\item \textsuperscript{29} Ex. 245 (four photographs).
\item \textsuperscript{30} Test. of C. Winters.
\end{itemize}
repositioned the doll still all the way to the right.31 B.S. was large for his age and much larger than the reenactment doll, which was about one-third the size of B.S.32

20. The photographs of the doll in the pack-and-play show a stain on the sheet covering the pack-and-play mattress. The stain is toward the center of the pack-and-play.33 The stain was from “purge fluid” that emerged from B.S.’s mouth at the time he died.34 During the reenactment, Licensee saw the stain for the first time. Because of his size, B.S.’s head, which had turned to the right35 sometime after he was placed in the pack-and-play, would have covered that spot when Licensee came to get him.36

21. Sergeant Long reported to the Department that Licensee lay B.S. down at a 45 degree angle.37

22. The reenactment photographs show only that the doll was placed to the side of the pack-and-play. Some of the perception of the doll being placed at a 45-degree angle is due to the rigidity of the doll.38

23. Licensee consistently reported to Detective Winters that she placed B.S. flat on his back.39

24. The statement in the County’s recommendation to the Department that “[Licensee] states that she laid the infant down at a 45-degree angle in the porta-crib and his face away” is inaccurate.40 Licensee did not state that she laid B.S. down at an angle. It was the observation of the law enforcement present at the reenactment, that the doll was placed at an angle.41

25. Detective Winters did not ask Licensee about the discrepancy between her statement and the doll placement because, from an investigatory standpoint, even had B.S. been placed at a 45-degree angle, that would not have caused his death. Mr. Lehman concurred that the angle would not have caused the baby to die.42

26. Detective Winters does not believe that Licensee caused the death of B.S. or that she poses any risk to children in her care.43
27. The sheriff’s investigation is still open because the Sheriff’s Office was waiting for the toxicology report to be completed.\textsuperscript{44}

III. The County’s Actions

28. Tara Braun is a supervisor of family and childcare, adoption foster care and child care licensing at the County. She has held the position for three months. Prior to that time, for five years she was a senior child protection social worker.\textsuperscript{45}

29. She was at work on October 27, 2017, when the report regarding B.S.’s death was made. She immediately went to talk to the County’s assessment supervisor, Cari Holm, to ask if she had received the report. They talked to two intake workers who said that they would begin a report. Ms. Holm and Ms. Braun then called Sergeant Long who was on the scene. Sargent Long, in his first conversation with Ms. Braun, stated that there had been an infant death and asked her to review Licensee’s file. Dawn Schenk, who is Licensee’s licensing worker, was not in the office that day.\textsuperscript{46}

30. Ms. Braun then spoke with Tim Hennessy at the Department and began to review Licensee’s file with another licensor. They found correction orders which Ms. Braun characterizes as primarily stemming from being over-capacity as to infants. However, Licensee was not over-capacity on the day of B.S.’s death.\textsuperscript{47}

31. Sargent Long told Ms. Braun that Licensee lay B.S. down for a nap at 11 a.m., that she fed him before outing him down, and that she had put him in a pack-and-play in her bedroom. He reported that during a demonstration Licensee demonstrated placing the child at a 45 degree angle with his back against the pack-and-play.\textsuperscript{48}

32. Ms. Braun received direction from the Department to issue a TIS.\textsuperscript{49}

33. A child protection assessment and child care licensing assessment are ongoing.\textsuperscript{50} The investigators are waiting for the toxicology reports.\textsuperscript{51}

34. Ms. Braun agrees that Licensee did not cause the death of B.S.\textsuperscript{52} She does not believe, with the information she has at this time, Licensee poses a risk of harm to children in her care, but she believes the file is incomplete without the toxicology report.\textsuperscript{53} The toxicology reports could change her assessment.\textsuperscript{54}

\begin{itemize}
\item \textsuperscript{44} Id.
\item \textsuperscript{45} Test. of T. Braun.
\item \textsuperscript{46} Id.
\item \textsuperscript{47} Id.
\item \textsuperscript{48} Id.
\item \textsuperscript{49} Id.
\item \textsuperscript{50} Id.
\item \textsuperscript{51} Id.
\item \textsuperscript{52} Id.
\item \textsuperscript{53} Id.
\item \textsuperscript{54} Id.
\end{itemize}
35. She also believes safe sleep concerns exist that are being investigated as part of the County’s licensing investigation.55

36. Dawn Schenk has been a childcare licensor with the County since May of 2012, and has been Licensee’s licensor since that time.56

37. Licensee was current on her SUIDS training on the day B.S. died.57

38. According to the safe sleep protocols, infants must be laid to sleep on their backs. 58

39. Placing a rolled-up towel under the mattress of a pack-and-play is a sleep violation.59 If a licensor found that violation, the County would issue a correction order and a fine.60

40. Licensee has provided consistent accounts about what occurred before B.S.’s death.

41. On October 27, 2017, the County recommended that the Department issue a temporary immediate suspension of Licensee’s family child care license.61

42. Licensee appealed the Order on October 30, 2017.62

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

CONCLUSIONS OF LAW

1. The Commissioner shall act immediately to temporarily suspend a license if the license holder’s actions or failure to comply with applicable law or rule, or the actions of other individuals or conditions in the program, pose an imminent risk of harm to the health, safety, or rights of persons served by the program.63

2. The scope of a hearing regarding an order for a temporary immediate suspension is limited solely to the issue of whether the temporary immediate suspension should remain in effect pending the Commissioner’s final order as to a licensing sanction.64

55 Id.
56 Test. of D Schenk.
57 Id.
58 Id.
59 Id.
60 Id.
61 Ex. 250 (Recommendation of Temporary Immediate Suspension).
62 Ex. 252.
64 Minn. Stat. § 245A.07, subd. 2a(a) (2016).
3. The Commissioner must demonstrate that reasonable cause exists to believe that the license holder's actions or failure to comply with applicable law or rule, or the actions of other individuals or conditions in the program, pose an imminent risk of harm to the health, safety, or rights of persons served by the program.65

4. "Reasonable cause" means specific, articulable facts or circumstances exist that 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.66

5. 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 physician directing an alternative sleeping position for the infant. The physician directive must be on a form approved by the Commissioner and must remain on file at the licensed location.67

6. When the Commissioner has determined there is reasonable cause to order the temporary immediate suspension of a license based on a violation of safe sleep requirements, as defined in Minn. Stat. § 245A.1435, the Commissioner is not required to demonstrate that an infant dies or was injured as a result of the safe sleep violations.68

7. The Department has not met its burden to show specific, articulable facts exist providing a reasonable suspicion that there is an imminent risk of harm to the health, safety, or rights of children served by Licensee's family child care.69

Based upon these Conclusions of Law, and for the reasons explained in the accompanying Memorandum which is incorporated herein by reference, the Administrative Law Judge makes the following:

**RECOMMENDATION**

The temporary immediate suspension of Licensee's family child care license should be **RESCINDED** pending issuance of a final order as to any licensing sanction.

Dated: December 12, 2017

Barbara Case
Administrative Law Judge

Reported: Digitally Recorded; No transcript prepared.

65 Id.
66 Id.
67 Minn. Stat. § 245A.1435 (a).
68 Minn. Stat. § 245A.07, subd. 2a (2016).
NOTICE

This Report is a recommendation, not a final decision. The Commissioner will make the final decision after a review of the record. The Commissioner may adopt, reject, or modify the Findings of Fact, Conclusions of Law, and Recommendation. The parties have 10 calendar days after receiving this Report to file Exceptions to the Report. At the end of the exceptions period, the record will close. The Commissioner then has 10 working days to issue the 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.

Under Minn. Stat. § 14.62, subd. 1 (2016), 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

The scope of this proceeding is very narrow. To meet its burden, the Department must show that specific, articulable facts exist giving rise to a reasonable suspicion that there is an imminent risk of harm to the children enrolled in Licensee’s child care.\(^70\) The Administrative Law Judge concludes that the Department has not met its burden and that the temporary immediate suspension of Licensee’s family child care license should be lifted pending the Commissioner’s final determination.

All of the witnesses that testified at the hearing in this matter were credible and forthcoming. The testimony at hearing demonstrated that this event was considered by everyone who testified to be a heartbreak not only for the family but for the community as well. It was also evident that all involved cared about each other as individuals and respected each other’s professional responsibilities.

The Department’s witnesses, especially Detective Winters, agreed that Licensee’s actions did not contribute to the death of B.S. Detective Winters testified that even if B.S. had been laid at an angle, the angle did not cause or contribute to his death. However, the fact that the weight of the evidence supports a preliminary conclusion that Licensee did not contribute to the death of B.S. does not answer the issue in this case. In fact, “when the Commissioner has determined there is reasonable cause to order the temporary immediate suspension of a license based on a violation of safe sleep requirements, the Commissioner is not required to demonstrate that an infant dies or was injured as a result of the safe sleep violations.”\(^71\)

Nonetheless, the Department still must prove reasonable cause to believe that Licensee poses an imminent risk of harm to the children enrolled in Licensee’s child care. Again, the primary witnesses for the Department, Detective Winters and Supervisor Braun, do not believe that Licensee poses such a risk. Though Ms. Braun

\(^70\) Minn. Stat. § 245A.07, subd. 2a(a).
\(^71\) Id.
pointed to the fact that the County is waiting for toxicology reports, she did not explain how the reports might show that Licensee poses a risk of harm.

Given the severity and nature of violations of safe sleep requirements, it was reasonable for the Department to suspend Licensee’s license while it further investigated this matter. However, by the day of the hearing, the weight of the evidence did not show that Licensee poses an imminent risk of harm. Licensee did nothing wrong on the day that B.S. died. The SUIDS licensing violations she admitted to during the investigation are serious. However, Ms. Schenk testified that if an investigator discovered those violations, the County would likely issue a correction order and a fine, not a TIS. It may seem logical that Licensee will comply with the requirements going forward but the Department has a responsibility and the means to put in place conditions that will make compliance more likely.

Licensee admitted that she violated safe sleep requirements each of the other four days that B.S. was in her daycare. However, the County’s licensor testified that the consequences for such a violation were likely to be a corrective order and a fine. Those recent violations and Licensee’s over-capacity correction orders would likely support a conditional license with conditions to help assure compliance in both areas. However, the Department’s own witnesses do not believe Licensee poses an imminent threat to the children in her care. Therefore, the Administrative Law Judge recommends that the temporary immediate suspension of Licensee’s family child care license be rescinded.

B. J. C.