RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

SHELLY EDGERTON
DIRECTOR

IN THE MATTER OF:

MAHS Docket No.: 16-015488

[redacted]
Petitioner

Agency Case No.: [redacted]

Case Type: **Expunction**

v

[redacted],
Respondent

_____/

Issued and entered
this 27th day of April 2017
by Vicki L. Armstrong
Administrative Law Judge

DECISION AND ORDER

PROCEDURAL HISTORY

This proceeding commenced with the issuance of a Notice of Telephone Prehearing Conference on [redacted], based on notification from the [redacted] (Department), Respondent, that it would not expunge the name or identifying information of [redacted], Petitioner, from the Michigan Child Abuse and Neglect Central Registry (Central Registry) for referral or complaint date of [redacted]. The action concerned Petitioner's alleged violation of the Child Protection Law, 1975 PA 238, as amended, MCL 722.621 *et seq.* (Act).

On [redacted], a Notice of Hearing was issued scheduling the hearing for [redacted], and [redacted]. On [redacted], Petitioner submitted a request for adjournment. On [redacted], an Order Granting Adjournment was issued, granting the adjournment of the [redacted], hearing date. The hearing remained scheduled for [redacted].

The hearing was held, as scheduled, on [redacted]. Petitioner represented herself at the proceeding. [redacted], Children's Protective Services (CPS) Supervisor, appeared on behalf of Respondent.

Respondent called CPS Investigator, [redacted]; [redacted] Detective, [redacted] r; [redacted]; [redacted]; and [redacted] to testify as witnesses. The following exhibits were offered by Respondent and admitted into the record as exhibits:

1. Respondent's Exhibit A is a copy of the Child Abuse/Neglect Action, dated [redacted].
2. Respondent's Exhibit B is a copy of a Certified Mail Receipt, dated [redacted].
3. Respondent's Exhibit C is a copy of the Notice of Action and Rights, dated [redacted].
4. Respondent's Exhibit D is a copy of the Children's Protective Services Investigation Report, dated [redacted].
5. Respondent's Exhibit E is a copy of the [redacted] Police Department Report, dated [redacted].
6. Respondent's Exhibit F is a copy of a letter to Petitioner from Licensing Consultant, [redacted], and the Special Investigation Report, both dated [redacted].
7. Respondent's Exhibit G is a copy of Child A's medical records from the [redacted], dated [redacted].
8. Respondent's Exhibit H is a copy of texts between Petitioner and Child A's mother, dated [redacted].
9. Respondent's Exhibit I is a copy of PSM 711-5, dated [redacted].
10. Respondent's Exhibit J is a copy of MCL 722.628e.

Petitioner testified on her own behalf. The following exhibits were offered by Petitioner and admitted into the record as exhibits:

1. Petitioner's Exhibit No. 1 is a copy of three DVD's containing trial testimony from [redacted], [redacted].
2. Petitioner's Exhibit No. 2 is a copy of Petitioner's witness and exhibit list, dated [redacted].
3. Petitioner's Exhibit No. 3 is a copy of Child A's medical records from [redacted], dated [redacted].

4. Petitioner's Exhibit No. 4 is a copy of Child A's medical records from [redacted], dated [redacted].

5. Petitioner's Exhibit No. 5 is a copy of Child A's medical records from [redacted], dated [redacted].

6. Petitioner's Exhibit No. 6 is a copy of Child A's medical records from [redacted], dated [redacted].

7. Petitioner's Exhibit No. 7 is a copy of Child A's medical records from [redacted], dated [redacted].

8. Petitioner's Exhibit No. 8 is a copy of a Head Circumference chart.

9. Petitioner's Exhibit No. 9 is a copy of Child A's medical records from [redacted], dated [redacted].

10. Petitioner's Exhibit No. 10 is a copy of Child A's medical records from [redacted], dated [redacted].

11. Petitioner's Exhibit No. 11 is a copy of Child A's medical records from [redacted], dated [redacted].

12. Petitioner's Exhibit No. 12 is a copy of Child A's medical records from [redacted], dated [redacted].

13. Petitioner's Exhibit No. 13 is a copy of an article entitled Benign enlargement of subarachnoid spaces: a cause of subdural hemorrhage in toddlers.

14. Petitioner's Exhibit No. 14 is a copy of an article entitled Macrocephaly.

15. Petitioner's Exhibit No. 15 is a copy of an article entitled Benign enlargement of the subarachnoid space in infancy.

16. Petitioner's Exhibit No. 16 is a copy of an article entitled Macrocephaly in infancy: benign enlargement of the subarachnoid spaces and subdural collections.

17. Petitioner's Exhibit No. 17 is a copy of an article entitled Subdural Hematomas in Infants with Benign Enlargement of the Subarachnoid Spaces Are Not Pathognomonic for Child Abuse.

18. Petitioner's Exhibit No. 18 is a copy of an article entitled The Significance of Macrocephaly or Enlarging Head Circumference in Infants with the Triad, dated [redacted].

19. Petitioner's Exhibit No. 19 is a copy of the [redacted], [redacted]'s Order of Acquittal, dated [redacted].

20. Petitioner's Exhibit No. 20 is a copy of a Power Point presentation entitled [redacted] Slides, dated [redacted].

The record was closed at the conclusion of the hearing.

ISSUES AND APPLICABLE LAW

The issue presented is whether Petitioner's record of abuse or neglect should be amended or expunged from the Child Abuse and Neglect Central Registry on the grounds that the report or record is not relevant or accurate evidence of abuse or neglect.

Section 2 of the Child Protection Law, *supra*, includes the following relevant definitions:

> Sec. 2. (f) "Child abuse" means harm or threatened harm to a child's health or welfare that occurs through nonaccidental physical or mental injury, sexual abuse, sexual exploitation, or maltreatment, by a parent, a legal guardian, or any other person responsible for the child's health or welfare or by a teacher, a teacher's aide, or a member of the clergy. MCL 722.622(f).
>
> Sec. 2. (j) "Child neglect" means harm or threatened harm to a child's health or welfare by a parent, legal guardian, or any other person responsible for the child's health or welfare that occurs through either of the following:
>
> (i) Negligent treatment, including the failure to provide adequate food, clothing, shelter, or medical care.
>
> (ii) Placing a child at an unreasonable risk to the child's health or welfare by failure of the parent, legal guardian, or other person responsible for the child's health or welfare to intervene to eliminate that risk when that person is able to do so and has, or should have, knowledge of the risk. MCL 722.622(j).

Section 7 of the Child Protection Law, *supra*, provides in pertinent part:

> Sec. 7.
> (1) The department shall maintain a statewide, electronic central registry to carry out the intent of this act.
> (2) Unless made public as specified information released under section 7d, a written report, document, or photograph

> filed with the department as provided in this act is a confidential record available only to 1 or more of the following: * * *.
> (4) If the department classifies a report of suspected child abuse or child neglect as a central registry case, the department shall maintain a record in the central registry and, within 30 days after the classification, shall notify in writing each person who is named in the record as a perpetrator of the child abuse or child neglect. * * * The notice shall set forth the person's right to request expunction of the record and the right to a hearing if the department refuses the request. * * *.
> (5) A person who is the subject of a report or record made under this act may request the department to amend an inaccurate report or record from the central registry and local office file. A person who is the subject of a report or record made under this act may request the department to expunge from the central registry a report or record by requesting a hearing under subsection (6). * * *. MCL 722.627.

According to Children's Protective Services Manual 711-5, a person responsible for the child's health or welfare means:

> A person who cares for the child in a licensed or registered child care center, group child care home, family child care home, children's camps or child caring institution, as defined in Section 1 of 1973 PA 116 or a licensed or unlicensed adult foster care family home or adult foster care small group home as defined in Section 3 of 1979 PA 218. PSM 711-5, pp 1-2 (5/1/2016).

FINDINGS OF FACT

Based upon the entire record in this matter, including the testimony and the exhibits, the following findings of fact are made:

1. Petitioner, [redacted] (DOB [redacted]), is a licensed child care provider and has been since [redacted]. At times relevant to this matter, Petitioner was the child care provider of Child A (DOB [redacted]). [Resp. Exh. D, p 2].

2. Child A's parents are [redacted] and [redacted]. [Resp. Exh. E, p 4].

3. On [redacted], on-call CPS Specialist, [redacted], investigated allegations of improper supervision, physical abuse and severe physical abuse against Petitioner for Child A being diagnosed at the emergency

department with a subdural hematoma, suspected to be a non-accidental injury caused while in Petitioner's care. [Resp. Exh. D, p 7-8].

4. On [redacted], at approximately 12:54 a.m., while Child A was at the emergency department at [redacted], the emergency department physician, [redacted] noted that Child A had a large head and that he was unable to visualize tympanic membrane (TM) due to cerumen. He did note that Child A had a healing scratch over her right forehead, otherwise atraumatic. [Petitioner's Exh. 5A].

5. On [redacted], on-call CPS Specialist [redacted] made contact with Child A and [redacted] at the [redacted]. [redacted] stated that Child A was a [redacted]-old child who was in daycare and was reported to have had a "60 second episode of jerking motions and a possible fever." [redacted] reported that Child A was reported to be in good health and was not sick at the moment. [redacted] explained that Child A was taken to the hospital in [redacted] and then transferred to [redacted] due to Child A having a subdural hematoma. [redacted] stated that Child A had a "6 millimeter off mid-line shift which meant that her brain was pushed over 6 millimeters." [redacted] showed on-call CPS Specialist [redacted] a head scan of Child A showing fresh and old blood around Child A's brain. [redacted] stated that the scan indicated that, most likely, Child A was shaken and the blood around her brain caused a seizure. [Resp. Exh. D, p 7-8].

6. On [redacted], at approximately 1:15 a.m., on-call CPS Specialist [redacted] spoke with Child A's mother, [redacted], at the hospital. [redacted] reported that she received a call at about 3:00 p.m. on [redacted], from Petitioner, who told her that Child A had a seizure. [redacted] stated she went to pick Child A up and took her home. [redacted] reported that Child A threw up, looked pale and was difficult to keep awake. [redacted] stated she took Child A to a neighbor who was a registered nurse (RN), who advised her to take Child A to the emergency room. [Resp. Exh. D, p 8].

7. On [redacted], the CPS investigation was transferred to CPS Investigator, [redacted]. CPS Investigator Wiseman spoke with CPS Specialist [redacted] who reported that there was medical evidence that Child A was shaken and a time frame was narrowed down when it likely occurred at the daycare. [Resp. Exh. D, p 9].

8. [redacted] stated to CPS Investigator [redacted] that Child A was home with her on Monday, [redacted], and Tuesday, [redacted]. [Resp. Exh. D, p 14].

9. Testimony during the hearing showed that Child A was not in Petitioner's care [redacted], through [redacted]. [Testimony of [redacted]].

10. On [redacted], at approximately 6:00 p.m., Child A was examined by [redacted] at [redacted] and diagnosed with shaken baby syndrome of different ages with a retinal hemorrhage on right and a left femur "bucket handle" fracture. [redacted] noted that Child A had initially presented with symptoms but had none subsequently. [redacted] also indicated that Child A was developmentally okay, to slightly delayed, and had mild macrocephaly. A note indicated that Child A had a possible metaphyseal corner fracture of the medial aspect of the distal left femur. Otherwise, unremarkable skeletal survey. The radiologist later informed the team that the area of concern was actually the left distal tibia and that there was a four-week follow-up imaging that was needed. [Petitioner's Exh. 6A-6C].

11. On [redacted], CPS Investigator [redacted] met with [redacted] Consultant, [redacted]. Consultant [redacted] indicated that all of the children enrolled in Petitioner's daycare were younger than school age and would be difficult to interview. Consultant [redacted] reported she had been in Petitioner's daycare previously and had met Child A's brother, who was not able to verbally communicate. Consultant [redacted] stated she was last at Petitioner's home on [redacted], and at that time, Petitioner stated that Child A cried a lot. Petitioner appeared annoyed with the fussiness, but was able to meet Child A's needs and attempted to comfort her during the visit. [Resp. Exh. D, p 10].

12. On [redacted], CPS Investigator [redacted] spoke with Social Worker, [redacted], from [redacted]. Social Worker [redacted] indicated that at first the babysitter appeared to be of concern for the recent injury, but there had been further tests which revealed blood products on the brain, which were chronic and could be from an old injury. Social Worker [redacted] reported that Child A also had a skeletal fracture (bucket handle fracture) consistent with non-accidental injury. Social Worker [redacted] stated that the medical documentation was now showing that a time frame could not be narrowed down as to when the injuries occurred. [Resp. Exh. D, p 10].

13. On [redacted], a case conference was held with [redacted] Supervisor, [redacted]. [redacted] Supervisor [redacted] was updated regarding the case activity and findings. A determination was made that interviews would occur with the biological parents as possible perpetrators and a safety plan would be developed as to the other child in the biological home. [Resp. Exh. D, p 10-11].

14. On [redacted], CPS Investigator [redacted] met with [redacted]. CPS Investigator [redacted] asked [redacted] if he could assist in determining a time frame of when Child A received her injuries. [redacted] said that Child A was diagnosed with Shaken Baby Syndrome. A skeletal survey showed recent marks on her leg, which could be a possible bone break. [redacted] explained the possible break occurs when a child's limbs flail

when they are being shaken. When the limb moves it sometimes breaks at the weakest point, which for a baby is near a joint. [redacted] stated that the marking on the skeletal survey appeared to a line indicative of a fracture and would be considered a "fresh" injury, but the medical documentation was not supportive, at this time, that the area was a definite break or that the marking was indicative of child abuse. [Resp. Exh. D, p 13].

15. On [redacted], [redacted] indicated that when Child A threw up it only indicated an increase in brain swelling. He explained that the fluid or blood could have been leaking for "days", prior to Child A throwing up, but she also could have thrown up immediately after the injury occurred. It all depended on how fast the fluid was building or how fast she was bleeding. [Resp. Exh. D, p 13].

16. On [redacted], [redacted] explained that a retinal hemorrhage could occur immediately after being shaken but they may be seen for a couple of weeks. So, the retinal damage could have occurred recently or the damage could be weeks old. [redacted] reported that Child A's brain scan was reviewed by a neurologist. The neurologist noticed that there was also fluid on Child A's brain which was determined to be "chronic" and could be indicative of prior trauma or could just be there in a normal developing baby. [redacted] explained that if old or chronic fluid was present and seen in the brain alone, a determination could not be made that Child A was abused. But, given the old fluid being present, as well as the new recent bleeding, the determination was that child abuse occurred. [Resp. Exh. D, p 13].

17. On [redacted], [redacted] stated that Child A's injuries were inflicted and she was diagnosed with shaken baby syndrome because of the subdural hematoma and retinal hemorrhage. CPS Investigator [redacted] asked [redacted] how quickly after a baby is shaken would the baby have a seizure. [redacted] replied that seizures happen when the injury happens, and it was unlikely that a baby would have a seizure a day after the injury occurred. [Resp. Exh. D, p 13].

18. [redacted] credibly testified during the hearing in the above captioned matter that the seizure could have occurred one to two days after being shaken. His initial impression was that Child A was very irritable, she was not seizing anymore, and she had an enlarged head. [redacted] saw no physical marks on Child A. [redacted] stated that Child A had a high-pitched cry, which indicated to him that there was irritation of the brain, pressure or blood or something like that. When [redacted] looked into Child A's right eye, he could see hemorrhages, which Child A could only have received from being shaken. [Testimony of [redacted] [redacted] on [redacted]].

19. [redacted] credibly testified that when he reviewed the CT from [redacted], he saw fresh blood and older-appearing fluid in the subdural space of the brain. [redacted] explained that that constellation of findings means shaken baby. [redacted] stated that there was no doubt in his mind that that was the cause. He explained that it was very difficult to say how the older-appearing blood, or chronic fluid, could be days or weeks old. It is usually from some kind of trauma, but the older or chronic fluid cannot be determined to be accidental or non-accidental. [redacted] stated that he was not saying that she was 100% shaken, but in his mind she was. [redacted] stated that it cannot determine when the shaking occurred. [redacted] said that "usually you have the seizure right after being shaken, but blood is very irritating to the brain and so you could have seizures later, but usually you have them early on, not later." [Testimony of [redacted] on [redacted]].

20. On cross-examination, [redacted] credibly testified that the age of the white blood (fresh blood) was one to two days old, as of [redacted]. The bleeding could have occurred right away, or up to one to two days later. [redacted] repeated the older or chronic fluid could not be dated. [Testimony of [redacted] on [redacted]].

21. On [redacted], while being interviewed by CPS Worker [redacted], [redacted] stated that she received a call from Petitioner around 3:01 p.m. on [redacted], telling her that Child A had had a seizure. [redacted] explained she picked Child A up at 4:15 p.m. and discovered Child A had thrown up. [redacted] called Child A's pediatrician. The pediatrician told [redacted] to bring Child A in right away. [redacted] took Child A and her son home and talked to her neighbor who was an emergency department RN. [redacted] stated that the RN looked Child A over and said Child A looked fine, but to still take Child A to the hospital. [redacted] arrived at the hospital with Child A at 5:45 p.m. [Resp. Exh. D, p 13-14].

22. On [redacted], CPS Investigator [redacted] asked [redacted] about the frustration she feels when the babies are crying. [redacted] stated that her husband handles Child A's fussiness by holding her and walking with her and sometimes looks at [redacted], like he does not know what to do, and he will give Child A to her. [redacted] said she had no concerns with how her husband has ever interacted with either of the kids. [redacted] explained the variety of things they used to calm Child A down when she cried or was fussy. Child A was allowed to soothe herself by crying it out, they put in a DVD she likes to watch, they change up activities, they hold her, put her in the swing, bouncy, play gym, or high chair. They just try to keep her occupied. [redacted] stated that Monday, [redacted], her husband was home alone with the kids and she did not notice anything unusual about Child A's behavior, or her husband, when she returned. On Tuesday, [redacted], [redacted] stated that she was the one who

stayed home with Child A when her husband had to leave. [redacted] indicated that no one else had baby sat for the kids through the past weekend or week. [Resp. Exh. D, p 13-14].

23. On [redacted], CPS Investigator [redacted] interviewed Petitioner. Petitioner stated that [redacted] was not easily calmed on [redacted]. Petitioner stated that she, and [redacted], were using text messages to communicate that Child A was crying again. Petitioner said Child A calmed down around noon and took a nap until 2:00 p.m. Petitioner stated that she checked on Child A frequently while she slept. At 2:00 p.m. Child A woke up and was still fussy. Petitioner tried feeding her and giving her a pacifier, then put her back in the bed with the fan on for white noise. Petitioner left the room where Child A was in the bed and Child A stopped crying about one to three minutes later. After Child A stopped crying, Petitioner checked on her and saw Child A's arms moving in a slow rowing motion, her hands were clenched, her eyes were closed, and she was moaning. Petitioner explained that she picked Child A up and she was very hot, so she took her sleeper off, and at that time Child A was limp. Petitioner said she held Child A up and out from her body to look at her face and was calling Child A's name, while slightly moving her up and down to rouse her. Petitioner called [redacted] immediately. [Resp. Exh. D, p 16-17].

24. On [redacted], CPS Investigator [redacted] had a case conference with MIC Supervisor [redacted]. A plan was made to have law enforcement rule out the biological parents as suspects before Child A was released from the hospital and into the care of [redacted]. [Resp. Exh. D, p 18].

25. On [redacted], CPS Investigator [redacted] called Detective [redacted], of the [redacted], who was also investigating the alleged child abuse. Detective [redacted] indicated he could not entirely rule out the parents as alleged suspects until he spoke with the doctor. [Resp. Exh. D, p 18].

26. On [redacted], CPS Investigator [redacted] received a message from Detective [redacted] that he had spoken with Child A's doctor in the Pediatric Intensive Care Unit (PICU), and at this time, Detective [redacted] could not completely rule out the parents as the doctor reported Child A's injuries could be minutes to days old, and the doctor could not narrow down a time frame any better. Detective [redacted] stated he had to speak with the parents before ruling them out as possible perpetrators, and asked CPS Investigator [redacted] to have the parents get in touch with him. [Resp. Exh. D, p 18].

27. On [redacted], Detective [redacted] called CPS Investigator [redacted] and stated that if CPS agreed that it was okay to release Child A into the biological parent's care, then the police department was in agreement. Detective [redacted] explained that the focus of the criminal investigation was on

Petitioner at this time and if that changed, he would notify CPS immediately and request Child A be taken into protective custody. Detective [redacted] reiterated that [redacted] at [redacted] said that Child A's injuries are "minutes to days old, less than five days old, but up to two days old." [Resp. Exh. D, p 19].

28. On [redacted], [redacted] opined regarding Child A's right retinal hemorrhage that he was "unsure if this particular retinal hemorrhage is traumatic vs atraumatic." [Petitioner's Exh. 9].

29. On [redacted], CPS Investigator [redacted] received a telephone call from [redacted], in [redacted]. [redacted] indicated that there was no way to determine a time frame of when the old or chronic subdural hematoma, shown on Child A's MRI, would have occurred. [Resp. Exh. D, p 25].

30. On [redacted], [redacted] told CPS Investigator [redacted] that Child A had had no further medical problems and had not had another seizure or thrown up again. [Resp. Exh. D, p 26].

31. On [redacted], Child A returned to [redacted] for follow-up of a possible left metaphyseal corner injury. The x-rays showed no bone or joint abnormality and no evidence of a healing fracture. [Petitioner's Exh. 3].

32. On [redacted], CPS Investigator [redacted] met Pediatric Neurosurgeon, [redacted]. [redacted] indicated that Child A was "macrocephalic" prior to the incident where she was shaken. [redacted] explained that Child A's head growth would be watched carefully. He indicated that the subdural hematoma, which showed up on the [redacted], MRI, was at least two weeks old. The determination of the age was based on a breakdown of the blood proteins that appeared on the MRI. However, no time frame of when the injury occurred could be determined. [redacted] explained that sometimes signs of old head injuries never disappear and will always show up on an MRI. [redacted] indicated that it was possible that when the old subdural hematoma occurred, after the injury, that Child A showed no outward signs that anything happened. Child A may have been fussy around that time and it was possible that she did not throw up or have a seizure at all. [Resp. Exh. D, p 26].

33. On [redacted], Detective [redacted] informed CPS Investigator [redacted] that he had completed the criminal investigation and would be requesting a warrant for 1st Degree Child Abuse, a 15-year felony, for Petitioner with the [redacted] office next week. [Resp. Exh. D, p 26].

34. On [redacted], [redacted], Child A, and CPS Investigator [redacted] were present for the meeting with Pediatric Neurosurgeon [redacted]. [redacted] explained that the "old" or "chronic" blood noticed on Child A's brain was from some sort of injury older than two weeks old, and could have occurred at least two months previous to the injury being noticed. The injury was caused from some sort of trauma, such as a fall or from intentional injury, such as a mild shaking. [redacted] stated that there was no way to determine how that injury originated or when it originated. He explained that there can be bleeding on the brain with no noticed symptoms. Based on how "old" the injury looked, [redacted] could also not tell where on Child A's head she was hit, if she was hit or where, or if outside force occurred. He explained that the difference between the "old" injury and the "new" injury was that the new injury had other symptoms and medical findings that were present along with the brain bleed, which resulted in a determination that Child A had been shaken. [redacted] also noted that Child A's head continued to grow rapidly and another MRI had been ordered. [Resp. Exh. D, p 28].

35. On [redacted], CPS Investigator [redacted] received a telephone call from [redacted] regarding the findings of the new MRI. [redacted] stated that they found the injury from [redacted], continued to bleed and Child A would need surgery to treat the injury. [Resp. Exh. D, p 28].

36. On [redacted], Child A was examined by [redacted] at the [redacted]. [redacted] noted that Child A had "a history of benign expansion of the subarachnoid spaces," and that Child A's "head circumference has continued to rapidly increase." [Petitioner's Exh. 10].

37. On [redacted], [redacted] noted in Child A's history that Child A was "an [redacted] female with a history of macrocephaly. In [redacted], the patient was diagnosed with a left greater than right subdural hematoma. The patient was followed in the neurosurgery clinic. The patient developed progressively worsening macrocephaly. The patient underwent a brain MRI which demonstrated a significant increase in the left frontal parieto-occipital chronic subdural hematoma. The options of continued conservative management versus surgical intervention were discussed with the patient's parents who elected for surgical intervention." [Petitioner's Exh. 11].

38. Child A was admitted to [redacted] on [redacted], and discharged [redacted]. [Petitioner's Exh. 9].

39. On [redacted], CPS Investigator [redacted] learned from Detective [redacted] that the [redacted] office still had not authorized the charges. [Resp. Exh. D, p 29].

40. On [redacted], [redacted] informed CPS Investigator [redacted] that Child A had the surgery to drain fluid from the injury she received on [redacted]. The surgery went well and Child A had no further medical needs at this time. [Resp. Exh. D, p 29].

41. On [redacted], Respondent placed Petitioner's name on the Central Registry as a perpetrator of Physical Abuse. [Resp. Exh. C].

42. On [redacted], [redacted] issued an Order of Acquittal following a jury trial for the charges of Child Abuse-1st Degree and Child Abuse-2nd Degree. [Petitioner's Exh. 19].

CONCLUSIONS OF LAW

The principles that govern judicial proceedings also apply to administrative hearings. The burden of proof is on the Respondent to prove, by a preponderance of the evidence, that relevant and accurate evidence of abuse or neglect exists and that the placement of Petitioner's name on the Central Registry was appropriate.

As a trier of fact, the Administrative Law Judge must determine the weight, the effect and the value of the evidence. The Administrative Law Judge must consider and weigh the testimony of all witnesses and evidence.

The protective services hearing process is a quasi-judicial, contested case proceeding required by law to determine if a petitioner's name must remain on the Central Registry as a perpetrator of abuse and/or neglect.

When a hearing is requested, the presiding Administrative Law Judge conducts a *de novo* review, in which the Respondent has the threshold burden to prove, by a preponderance of the evidence, that a petitioner has committed child abuse and/or child neglect as defined by the Child Protection Law, *supra*. If this threshold burden is met, then the Respondent must also prove that the matter has been properly placed on the Central Registry in conjunction with the provisions of the Child Protection Law, MCL 722.628d.

Completion of the structured decision-making tool ("Risk Assessment") is not required when a registered child care organization (in this case a daycare) is investigated. However, the Respondent still has the burden to establish a preponderance of evidence that abuse or neglect was committed before any Central Registry placement can be upheld on appeal.

In this matter, Petitioner was placed on the Central Registry specifically for Physical Abuse. The policy definition of physical abuse (injury) is a nonaccidental occurrence of a subdural hemorrhage or hematoma. PSM 711-5, p 3 (5/1/2016).

A preponderance of evidence is evidence which is of a greater weight or more convincing than evidence offered in opposition to it. It is simply that evidence which outweighs the evidence offered to oppose it. *Martucci v Detroit Commissioner of Police*, 322 Mich 270; 33 NW2d 789 (1948).

Based on the above findings of fact, Respondent has not proven by a preponderance of the evidence that it was legally appropriate to list Petitioner's name on Michigan's Central Registry. First, the record evidence shows that while most of the physicians were in agreement that Child A had been shaken, there was no evidence presented on who or when Child A was shaken.

The physicians agreed that Child A had been diagnosed with macrocephaly prior to the alleged injury on [redacted]. The basic facts are that when Child A was examined at the hospital, she had a subdural hematoma and a "6 millimeter off mid-line shift which meant that her brain was pushed over 6 millimeters." The initial head scan showed Child A had fresh and old blood around her brain. [redacted] credibly stated that the scan indicated, most likely, that Child A had been shaken and the blood around her brain had caused a seizure.

[redacted] found that Child A had a retinal hemorrhage on the right and a left femur "bucket handle" fracture. On [redacted], [redacted] opined that he was unsure if Child A's right retinal hemorrhage was traumatic versus atraumatic. On [redacted], x-rays showed no bone or joint abnormality and no evidence of a healing fracture of Child A's left femur.

Beginning on [redacted], CPS was informed that the medical documentation was now showing that a time frame could not be narrowed down as to when the injuries occurred. [redacted] on [redacted], also informed CPS, that the fluid or blood could have been leaking for "days" prior to Child A throwing up, but she also could have thrown up immediately after the injury occurred. [redacted] explained that a retinal hemorrhage could occur immediately after being shaken, or the damage could be weeks old. The neurologist noticed that there was also fluid on Child A's brain which was determined to be "chronic" and could be indicative of prior trauma or could just be there in a normally developing baby. [redacted] testified, during the hearing in the above captioned matter, that the seizure could have occurred one to two days after being shaken. In addition, [redacted] at [redacted] said that Child A's injuries were "minutes to days old, less than five days old, but up to two days old."

On [redacted], Pediatric Neurosurgeon [redacted] indicated that the subdural hematoma, which showed up on the [redacted], MRI, was at least two weeks old. The determination of the age of the subdural hematoma was based on a breakdown of the blood proteins that appeared on the MRI. However, no time frame of when the injury occurred could be determined.

According to Child A's mother, [redacted], Child A was with her biological parents in her home from Saturday, [redacted], through [redacted], and [redacted], was her first time back at daycare.

Further, after learning that a time frame could not be narrowed down, a determination was made by CPS to interview the biological parents as possible perpetrators. Based on interviews, CPS found the biological parents were not the perpetrators and Child A was released into their care.

Accordingly, after reviewing the hearing record in full and the applicable law, it is the ruling of this ALJ that the Petitioner's name was not properly placed on the Central Registry. Therefore, Respondent's refusal to remove Petitioner's name from the Central Registry is reversed.

ORDER

NOW THEREFORE, IT IS ORDERED that:

1. Respondent's denial decision as to Petitioner's placement on the Central Registry for complaint or referral date of [redacted], is hereby **REVERSED**.

2. Respondent is hereby ORDERED to expunge Petitioner's name from the Central Registry for the complaint or referral date of [redacted], within 10 days of the date of mailing of this Decision and Order.

Vicki L. Armstrong
Administrative Law Judge

APPEAL NOTICE: Within sixty (60) days after the date of mailing of this Decision and Order, a petition for review may be filed in a court of proper jurisdiction. The Michigan Administrative Hearing System (MAHS), on its own motion or on request of a party, may order rehearing or reconsideration. A written request for rehearing or reconsideration must be filed within sixty (60) days after the date of mailing of this Decision and Order with the Michigan Administrative Hearing System, P.O. Box 30763, Lansing, MI 48909 (fax 517-373-4147), with a copy to all parties to the proceeding.

PROOF OF SERVICE

I hereby state, to the best of my knowledge, information and belief, that a copy of the foregoing document was served upon all parties and/or attorneys of record in this matter by Inter-Departmental mail to those parties employed by the State of Michigan and by UPS/Next Day Air, facsimile, and/or by mailing same to them via first class mail and/or certified mail, return receipt requested, at their respective addresses as disclosed below this [redacted]

[redacted]

Michigan Administrative Hearing System

[redacted]