

MALTREATMENT INVESTIGATION MEMORANDUM
Office of Inspector General, Licensing Division
Public Information

Minnesota Statutes, section 260E.01, paragraph (a), "The legislature hereby declares that the public policy of this state is to protect children whose health or welfare may be jeopardized through maltreatment."

Report Number: 202300510

Date Issued: April 26, 2023

Name and Address of Facility Investigated:

MCF-Red Wing
1079 Highway 292
Red Wing, MN 55066

Disposition: Maltreatment determined as to neglect of an alleged victim by a staff person.

License Number and Program Type:

1036934-CRF (Children's Residential Facility/Department of Corrections)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that a staff person (SP) had a romantic relationship with an alleged victim (AV), who was 17 years old at the time s/he was at the facility.

Date of Incident(s): Prior to January 17, 2023

Nature of Alleged Maltreatment Pursuant to Minnesota Statutes, section 260E.03, subdivision 20; and subdivision 15, paragraph (a), clauses (1) and (2):

"Sexual abuse" means the subjection of a child by a person responsible for the child's care, by a person who has a significant relationship to the child, or by a person in a current or recent position of authority to any act that constitutes a violation of section 609.342 (criminal sexual conduct in the first degree), 609.343 (criminal sexual conduct in the second degree), 609.344 (criminal sexual conduct in the third degree), 609.345 (criminal sexual conduct in the fourth degree), or 609.3451 (criminal sexual conduct in the fifth degree). Sexual abuse includes threatened sexual abuse.

Failure by a person responsible for a child's care to supply a child with necessary food, clothing, shelter, health,

medical, or other care required for the child's physical or mental health when reasonably able to do so.

Failure to protect a child from conditions or actions that seriously endanger the child's physical or mental health when reasonably able to do so.

Summary of Findings:

Pertinent information was obtained during a site visit conducted on January 26, 2023; from documentation at the facility; and through interviews conducted with facility staff persons (P1 and P2). This investigator met the AV, but s/he declined to complete an interview with this investigator. However, the AV provided information to P1 regarding the allegations. Two letters, one certified, were sent to the SP requesting an interview with this investigator, but the SP did not respond to the letters.

The facility was a juvenile residential facility operated by the Minnesota Department Corrections that focused on encouraging the development of healthy living and social skills to prepare youths to re-enter the community. The facility had a video recording system that recorded common areas of the facility and most areas on the facility grounds.

The AV was admitted to the facility as a condition of probation; s/he had past convictions for first degree aggravated robbery, had other pending charges, and did not attend school regularly. The AV was 17 years old when the incidents with the SP occurred and his/her diagnoses included other specified trauma and stressor related disorder, attention deficit hyperactivity disorder, combined presentation, oppositional defiant conduct, and unspecified psychosis, likely related to insomnia and trauma. The SP was six years older than the AV.

Facility documentation and information from P1 and P2 (a supervisory staff person) showed the following:

P1 said that the facility became aware of concerns regarding inappropriate boundaries between the SP and AV, then reviewed video recordings of interactions between them and began an internal investigation into the concerns. Several youths who did not want to be considered "snitches," provided information to P1 that the AV and SP told each other, "I love you," and discussed "hooking up" after the AV was discharged from the facility. In addition, the SP brought the AV potato chips, snack crackers, allowed the AV to make "extra" telephone calls, and walked with the VA and sat by him/her more often than with other youths. The SP also went with the AV when the AV took out the garbage after dark but did not accompany other youths when they took the garbage out.

P1 reviewed recordings made by the facility's video recording system and provided them to this investigator. The recordings showed that on December 8, 2022, the SP and AV were walking with a group of youths between two buildings on the facility grounds. The SP and AV walked a few feet behind the group, which twice caused the group to pause and wait for the SP and VA to catch up. There were video recordings of incidents not related to alleged maltreatment or the allegations in this report that showed the SP engaged in conduct which violated the facility's policies and procedures. P1 and P2 took spoke with the SP regarding those concerns and they were not investigated in this report.

The AV denied that s/he and the SP "touched" each other in a sexual manner. However, the AV acknowledged that there were times when s/he and the SP were physically close to each other and that they had agreed to contact each other via social media after the AV was discharged from the facility. The SP also permitted the AV to remain in common areas of the facility when the AV should have been in his/her bedroom when the AV had

“good behavior,” but s/he was unable to define what good behavior was. The AV did not plan to be significant others with the SP, but s/he wanted to attempt to have a sexual relationship with the SP after the AV was discharged.

The SP did not complete an interview with this investigator, but when the SP spoke with P1, s/he said that on unspecified dates s/he gave personal food items to the AV and told the AV personal information about his/her history. The SP understood that his/her actions might be viewed as favoritism or being too close to a youth. However, the SP denied that s/he and the AV told each other they loved each other and denied that s/he planned to have a relationship with the AV upon his/her discharge from the facility.

The facility's *Personal Association between Staff and Offenders policy* stated that staff persons were not to have contact with youths who currently or formerly received services at the facility other than contacts required by departmental work assignments.

Giving or accepting gifts, articles, special favors (including food) to youths or their families was also not allowed. Employees who failed to report personal associations might be disciplined up to and including discharge from employment.

The facility's personnel and training records showed that staff persons interviewed for this report were trained on the facility's policies and procedures and on the Maltreatment of Minors Act prior to the incident. On October 14, 2022, the SP had a “Supervisory Conference” in which s/he and his/her supervisor discussed concerns that the SP did not treat the youths equally at the facility.

Conclusion:

A. Maltreatment:

Several youths provided consistent information to P1 that the SP and AV said that they loved each other and discussed “hooking up.” In addition, the SP gave the AV preferential treatment when s/he brought the AV snacks, allowed him/her to make additional phone calls, remain in common areas when s/he should be in his/her bedroom, and sat/walked with the AV more often than with other youths.

According to the AV, s/he and the SP did not have sexual contact, but they were physically close to each other at times, and had agreed to connect via social media after the AV was discharged. The AV acknowledged that the SP let the AV remain in common areas of the facility when s/he should have been in his/her bedroom and the AV wanted to try to have a sexual relationship with the SP.

The SP provided information to P1 showing that s/he gave personal food items to the AV and told the AV personal information about his/her history. The SP knew that his/her actions might be considered as favoritism, but s/he denied that s/he and the AV told each other they loved each other and denied that s/he planned to have a relationship with the AV upon his/her discharge from the facility.

Information was consistent that the SP did not follow the facility's policies and procedures in his/her interactions with the AV and a video showed the SP walking with the AV behind a group, so the group had to wait for the SP and AV to catch up.

Although there were concerns that the SP had a romantic relationship with the AV, given that no information showed that the SP had sexual contact with the AV, there was not a preponderance of the evidence that the SP had sexual contact with the AV.

It was not determined that sexual abuse occurred ("sexual abuse" means the subjection of a child by a person responsible for the child's care, by a person who has a significant relationship to the child, or by a person in a current or recent position of authority to any act that constitutes a violation of section 609.342 (criminal sexual conduct in the first degree), 609.343 (criminal sexual conduct in the second degree), 609.344 (criminal sexual conduct in the third degree), 609.345 (criminal sexual conduct in the fourth degree), or 609.3451 (criminal sexual conduct in the fifth degree). Sexual abuse includes threatened sexual abuse).

Although the SP denied that s/he and the AV told each other they loved each other and denied that s/he planned to have a relationship with the AV upon his/her discharge from the facility, the SP had reason to minimize his/her actions for fear of consequences and several youths provided consistent information that this occurred.

In addition, the SP gave the AV preferential treatment when s/he brought the AV snacks, allowed him/her to make additional phone calls, remain in common areas when s/he should be in his/her bedroom, and sat/walked with the AV more often than with other youths.

The facility encouraged the development of healthy living and social skills to prepare youths to re-enter the community. The AV needed supports to develop and maintain necessary life and social skills, including assistance to successfully complete high school and to access appropriate care from community mental health care professionals.

The AV, who was 17 years old when the incidents occurred, thought s/he would have future social interaction with the SP, who was 6 years older than the AV, after s/he left the facility, so it was likely that the AV's ability to have a consistent understanding of the parameters of a therapeutic relationship which could interfere with other attempts to provide him/her with therapeutic services, now and in the future, was hindered. Therefore, there was a preponderance of the evidence the SP's interactions with the AV were detrimental to the AV's ongoing mental health which was a failure to supply the AV with necessary care and a failure to protect the AV from conditions or actions that seriously endanger the AV's physical or mental health when reasonably able to do so.

It was determined that neglect occurred (failure by a person responsible for a child's care to supply a child with necessary food, clothing, shelter, health, medical, or other care required for the child's physical or mental health when reasonably able to do so. Failure to protect a child from conditions or actions that seriously endanger the child's physical or mental health when reasonably able to do so).

B. Responsibility pursuant to Minnesota Statutes, section 260E.30, subdivision 4, paragraph (a), clauses (1) and (2):

When determining whether the facility or individual is the responsible party, or whether both the facility and the individual are responsible for determined maltreatment in a facility, the investigating agency shall consider at least the following mitigating factors:

- (1) whether the actions of the facility or the individual caregivers were according to, and followed the terms of, an erroneous physician order, prescription, individual care plan, or directive; however, this is not a mitigating factor when the facility or caregiver was responsible for the issuance of the erroneous order, prescription, individual care plan, or directive or knew or should have known of the errors and took no reasonable measures to correct the defect before administering care;
- (2) comparative responsibility between the facility, other caregivers, and requirements placed upon an employee, including the facility's compliance with related regulatory standards and the adequacy of facility policies and procedures, facility training, an individual's participation in the training, the caregiver's supervision, and facility staffing levels and the scope of the individual employee's authority and discretion; and
- (3) whether the facility or individual followed professional standards in exercising professional judgment.

The SP was trained on the Reporting of Maltreatment of Minors Act and the facilities policies and procedures. The SP was responsible for maltreatment of the AV.

C. Recurring and/or Serious Maltreatment:

The Office of Inspector General is required to evaluate whether substantiated maltreatment by an individual meets the statutory criteria to be determined as "recurring or serious." Individuals determined to be responsible for recurring or serious maltreatment are disqualified from providing direct contact services. Minnesota Statutes, section 245C.02, subdivision 16, states:

"Recurring maltreatment" means more than one incident of maltreatment for which there is a preponderance of evidence that maltreatment occurred and that the subject was responsible for the maltreatment.

Minnesota Statutes, section 245C.02, subdivision 18, states:

"Serious maltreatment" means sexual abuse, maltreatment resulting in death, neglect resulting in serious injury which reasonably requires the care of a physician whether or not the care of a physician was sought, or abuse resulting in serious injury. For purposes of this definition, "care of a physician" is treatment received or ordered by a physician, physician assistant, or nurse practitioner, but does not include diagnostic testing, assessment, or observation; the application of, recommendation to use, or prescription solely for a remedy that is available over the counter without a prescription; or a prescription solely for a topical antibiotic to treat burns when there is no follow-up appointment. For purposes of this definition, "abuse resulting in serious injury" means: bruises, bites, skin laceration, or tissue damage; fractures; dislocations; evidence of internal injuries; head injuries with loss of consciousness; extensive second-degree or third-degree burns and other burns for which complications are present; extensive second-degree or third-degree frostbite and other frostbite for which complications are present; irreversible mobility or avulsion of teeth; injuries to the eyes; ingestion of foreign substances and objects that are harmful; near drowning; and heat exhaustion or sunstroke. Serious maltreatment includes neglect when it results in criminal sexual conduct against a child or vulnerable adult.

It was determined that the substantiated neglect for which the SP was responsible did not meet statutory criteria to be determined as recurring because the SP's pattern of behavior was considered a single incident. The maltreatment for which the SP was responsible was not serious because the AV did not sustain a serious injury as defined by statute from the maltreatment.

Pursuant to Minnesota Statutes, section 260E.35, subdivision 6, paragraph © all investigative data maintained in this report will be kept by the Department of Human Services for at least ten years after the date of the final entry in the report.

Action Taken by Facility:

The facility was licensed by the Department of Corrections and was not required to complete an *Internal Review*. On December 16, 2022, the SP's employment at the facility ended.

Action Taken by Department of Human Services, Office of Inspector General:

The SP was not disqualified from providing direct care services as a result of the maltreatment determination in this report. However, the SP was notified by the Office of Inspector General that any further substantiated act of maltreatment, whether or not the act meets the criteria for "serious," will automatically meet the criteria for "recurring" and will result in the disqualification of the SP. The determination that the SP was responsible for maltreatment is subject to appeal.

Because this facility was licensed by the Minnesota Department of Corrections, a copy of this report was sent to them to address any policy violations identified in this report.

Certification:

The information collection procedures followed in this investigation were pursuant to Minnesota Statutes, section 260E.30, subdivision 6, paragraph (c). All individuals that are subjects of data in this investigation have the right to obtain private data on themselves which was collected, created, or maintained by the Department of Human Services.