DEPARTMENT OF HUMAN SERVICES

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: 202208851

Date Issued: June 30, 2023

Name and Address of Facility Investigated:

Minnesota J.C.C. Early Childhood Center
4330 Cedar Lake Road South
St. Louis, Park, MN 55416

License Number and Program Type:

801164-CCC (Child Care Center)

Investigator(s):

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Disposition:

Allegation One: A nonmaltreatment mistake to AV1 by SP1 and SP2 was not maltreatment.

Allegation Two: Maltreatment not determined.

Allegation Three: Maltreatment determined as to physical abuse and neglect of multiple alleged victims by a staff person.

Suspected Maltreatment Reported:

Allegation One: It was reported that an alleged victim (AV1) was unsupervised on the facility playground, including up to 40 minutes, and was not dressed appropriately for the weather.

Allegation Two: It was reported that an alleged victim (AV3) was unsupervised in the facility hallway for five minutes.

Allegation Three: It was reported that there were multiple concerns with a staff person's (SP1's) interactions with children.

Date of Incident(s): Ongoing and prior to, October 25, 2022

Nature of Alleged Maltreatment Pursuant to Minnesota Statutes, section 260E.03, subdivision 15, paragraph (a), clauses (1) and (2); subdivision 18, paragraph (a); and subdivision 23, paragraph (a):

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.

"Physical abuse" means any physical injury, mental injury, or threatened injury, inflicted by a person responsible for the child's care on a child other than by accidental means. "Threatened injury" means a statement, overt act, condition, or status that represents a substantial risk of physical or sexual abuse or mental injury.

Summary of Findings:

Pertinent information was obtained during a site visit conducted on November 10, 2022; from documentation at the facility; and through 9 interviews conducted with eight facility staff persons (SP1, SP2, P1, P2, P3, P4, P5, and P7), a supervisory staff person (P6). AV1's-AV16's family members were also contacted regarding the investigation. Attempts were made to contact and interview SP1 and P3 for additional information, but the attempts were not successful.

Facility documentation showed that SP1, SP2, P1, P2, P3, P4, P5, P6, and P7 each received training on the Reporting of Maltreatment of Minors Act and on the facility's policies and procedures, including behavior guidance and the risk reduction plan, prior to the incident.

Allegation One: *It was reported that AV1 was unsupervised on the facility playground, including up to 40 minutes, and was not dressed appropriately for the weather.*

AV1 was approximately 18 months old at the time of the incident and enrolled in a younger toddler classroom. (Note: On the date of the incident, the typical teachers in AV1's classroom were both out sick. Therefore, the children, including AV1, were moved to one of two older toddler classrooms. Specifically, AV1 was moved to SP1's and SP2's classroom).

Although there was an initial concern that AV1 may have been on the playground for up to 40 minutes, video reviewed by the facility showed that AV1 was outside approximately five minutes.

An email from a supervisory staff person (P8) and the *Child Care Center Risk Reduction Plan 2022-2023* provided the following information:

- The facility had many classrooms, including an infant classroom, three toddler classrooms, two preschool classrooms, and a pre-K classroom. The facility was in a large community center with many entrances and people "coming and going" each day. However, the facility was "behind locked doors [within the community center]" and required a key card to gain access.

- Staff persons were to "always" be within sight and sound of children. All children were signed in and out on a classroom clipboard, which stayed with staff persons, to ensure that staff persons had a list of the children in attendance. Children were "always" counted before they left a space and upon entering a new space to ensure the count matched what was on the sign in/out sheet. When transitioning between areas, children were to be in a line with one staff person at each end of the line. When a child went to

  their lockers (which were in a hallway outside of the classrooms), one staff person was to be in the classroom door watching the child in the hallway.

- There were three separate outdoor play areas for each age group the facility served (including an infant play area, a toddler play area, and a preschool play area). Children accessed the play areas via exterior classroom doors. Each play area had age-appropriate equipment. The toddler play area was surrounded on three sides by the walls of the building and a fence on the fourth side. The fence separated the toddler and preschool play areas and had one gate with a latch that led to the preschool play area. The preschool play area had a nine-foot-tall fence with a gate that led to a community center pool, but that gate was "always" locked with a "padlock and chain." The preschool play area had another nine-foot-tall fence with a gate that accessed a grassy area (which was 100 yards from the facility parking lot), but that gate was "always" locked from the outside. However, there was a "push bar" to open the gate to exit the play area but P8 said that a toddler aged child was not able to reach the push bar and/or did not have the strength to push open the gate via the push bar.

P5 provided the following information:

- In approximately October 2022 (later determined to be October 25, 2022), P5 and a staff person (P17) were working in the pre-K classroom. Around 12:30 p.m., P5's and P17's classroom finished lunch and then went outside to play on the preschool playground. Shortly after getting outside, P17 asked P5 why there was a child on the toddler playground, which was next to the preschool playground. P5 then went to see who the child was and saw AV1 sitting on a "step" on the toddler playground by him/herself. AV1 was not crying and was "sitting nice and quiet." It was about 40 degrees Fahrenheit outside and AV1 was wearing a sweatshirt but no jacket. There were no injuries to AV1.

- P5 then went to P4's exterior classroom door to ask P4 if AV1 was in his/her class. P4 said, "No," and that AV1 was in SP1's and SP2's classroom. P4 then came outside and picked up AV1. P4told P5 that AV1 was a "little cold." P4 and P5 then took AV1 to SP1's and SP2's classroom where both asked SP1 and SP2 how long AV1 was unsupervised and both said, "Five minutes." P4 and P5 then each returned to their respective classrooms.

- At times, staff persons from various classrooms took the children outside to run and get their "sillies out" for five or ten minutes and then came back inside. P5 thought that AV1's classroom did so on the date of the incident because AV1 was not wearing a coat when AV1 was found outside.

- Later that afternoon, P5 notified P6 and P8 of the incident. P6 and P8 were "surprised and frustrated" and P6 asked P5 "lots of questions."

- The playground was a space that needed "extra eyes" and staff persons were trained to do head counts. However, staff persons did not document the head counts but had an attendance record for the classroom to know how many children were present. P5 thought that SP1 and SP2 may have forgotten AV1 outside and did not think that AV1 was documented on SP1's and SP2's classroom attendance record because AV1 was not typically in their classroom but in another classroom (Note: This investigator requested the classroom attendance record from the facility for the date of the incident but did not receive it).

- Although AV1 was not injured, risks to AV1 being unsupervised included that AV1 could have gotten injured, including on the play equipment. AV1 could not have exited the playground because it was

"pretty secure."

P1 and P4 provided the following information:

- On October 25, 2022, P1 and P4 were working together in one of the older toddler classrooms. P4 said that it was a "really crazy day" because the staff persons in AV1's classroom were out sick so P1's/P4's and SP1's/SP2's classroom were "splitting" the children.

- Around 12:30 or 12:40 p.m., towards the end of lunch, P5 knocked on P1's and P4's classroom window and said that AV1 was "lingering" outside on the toddler playground. P5 asked P1 and P4 if AV1 was in their classroom and they said, "No," but that AV1 was in SP1's and SP2's classroom. P4 then went outside to bring AV1 back to SP1's and SP2's classroom. When P4 got to AV1, P4 hugged AV1 and noticed that AV1's hands were "freezing cold." AV1 was not wearing a jacket or mittens/gloves. AV1 was not crying and was not injured.

- P4 then brought AV1 to SP1's and SP2's room. When P4 returned AV1, SP1 "cursed." SP2 said, "Oh my God. Oh my God. How did we do this?" and SP2 said that SP1 had counted the children. P4 did not think that SP1 or SP2 "noticed" that AV1 was outside prior to P4 returning AV1 to their room. P4 asked SP1 how long AV1 was outside and SP1 said "five minutes."

- P1 said that risks to AV1 being unsupervised included the "cold" as it was around 40 degrees Fahrenheit and AV1 getting injured. P1 did not think that AV1 could have exited the play area due to the gates.

- P1 said that both SP1 and SP2 were responsible for ensuring the supervision of the children in the classroom. Staff persons were "required" to "count all the time," including before leaving or entering an area. P4 had worked with SP2 who normally "counts every time they go through the door."

P7 provided the following information:

- On the date of the incident, around 11:30 and 11:40 a.m., P7 and P15 were in the infant classroom getting lunch ready for the children. The infant room had a "big window" that faced the toddler and preschool playgrounds. At this time, P7 and P15 saw SP1's and SP2's "entire class" outside with no jackets, hats, or mittens. However, SP1 and SP2 both had jackets on. P15 told P7 that it was "really cold for [the children] not to have jackets." They were outside for "at least" 10 minutes. P7 knew the time because P7 and P15 were making bottles prior to lunch, which took about 10 minutes, and SP1's and SP2 class was outside during that time.

- P7 had "no idea" why the children were not wearing jackets, hats, or mittens. P7 had seen the younger toddler classroom outside earlier that day and they were all dressed appropriately. (Information obtained showed that the younger toddler classroom was closed on the day of the incident and so would not have been on the playground.)

- At some point after, P7 heard from another staff person that a child had "gotten left behind" but P7 did not see that.

- P7 was trained to do head counts when leaving the play area and once back inside. P7 had not heard SP1 count prior but said that s/he often saw SP1 touching the children's heads as they went inside.

- Risks to AV1 being unsupervised on the playground included AV1 climbing on equipment and falling off. There was also a gate from the toddler playground that led to the preschool playground but that was "generally closed." However, there were children who were able to open the gate by pushing on the handle (Note: P8 told this investigator that the toddler aged children were not able to open the gate as they were not able to reach the latch).

P3 was working at the facility on the date of the incident and was told that a child was left outside on one of the "colder days" for five minutes without a coat or hat. However, P3 was not involved in the incident. Staff persons were trained to count children throughout the day. Staff persons did not document the counts but said aloud to the other staff person in the room how many children they had counted.

P2 was not aware of an incident where a child was unsupervised on the playground. However, when P2 worked with SP1, s/he did not see SP1 do headcounts and said that SP1 was on his/her "phone a lot" and was not "super engaged" with the children. P2 "believed" that staff persons were trained to do head counts but had not been told to do so by the facility. However, P2 worked at other similar licensed childcare centers and had been trained to do them there.

P6 provided the following information:

- P6 did not recall the "exact" date of the incident but said that it was a "Tuesday" in October 2022. On that date, the two teachers in the "youngest" toddler classroom were not able to come into work so the children in that room were "split" into the two older classrooms, including AV1 who was placed in SP1's and SP2's classroom. The two older classrooms were still within the required ratio with the additional children and had about 12 children each.

- Around 11:20 a.m., SP1's and SP2's classroom had just returned from swimming in the community center (which they did every Tuesday), so P6 and another supervisory staff person (P18) helped get the children dressed and ready for lunch. Around noon, once the children sat down for lunch, P6 and P18 left the room.

- Later that day, after the children were sleeping, P5 told P6 and P8 that AV1 got "left on the playground for a few minutes." At some point, P6 and P8 also received an email from P4 explaining the "situation in more detail." P6 and P8 then met with about seven staff persons to discuss "everyone's story." P6 said that "everyone" had a "little different story," including that "no one was able to confirm what time of day [the incident] happened" or how long AV1 was unsupervised.

- P6 and P8 also looked at video footage of the incident and determined that no children were outside during the time that some staff persons said they were (prior to lunch). P6 did not know how "long" AV1 was unsupervised as the video footage stopped recording when there was "no motion detected" but that it was only a "few minutes."

- The facility was not "denying" that AV1 was left outside but it was not as long as some staff persons said it was. Leaving a child outside for "any amount of time" was "not okay." There were no injuries to AV1 and

  AV1 was not crying. Although there were no injuries to AV1, risks of being unsupervised could have included AV1 getting hurt.

- Staff persons were trained to count the children when coming inside and during "every transition" and "every activity." The counts were not documented. However, there was an attendance sheet to know how many children were present in the class each day. On the date of the incident, when SP1 and SP2 came inside, SP1 and SP2 had "miscounted." P6 said that AV1 was not on the classroom attendance sheet due to AV1 not typically being in SP1's and SP2's classroom. However, SP1 and SP2 "knew" the total number of children they had in their classroom that day as it was noted on the classroom app.

- When this investigator asked P6 which staff person was supposed to count when there was more than one staff person working in a classroom, P6 said that staff persons had "really good communication." The staff person holding open the door was supposed to "help" the children inside and the last staff person in was supposed to count. However, there was not one staff person assigned to either task.

- P6 did not have any concerns with SP1's and SP2's supervision of the children at the time of the incident. However, it was "not okay" that AV1 was left unsupervised outside.

The *Minnesota JCC Employee Performance Improvement Plan*; an email from P4 to P8 dated October 26, 2022; and an email dated November 9, 2022, sent from P8 to the childcare center licensor (L) provided the following additional information:

- On October 26, 2022, P4 emailed P8 stating that on October 25, 2022, AV1 was left unsupervised. P4 told P8 that the temperature was 41 degrees Fahrenheit with "cloudy sky." P4 said that AV1 was too young to "share" his/her feelings about the incident but that "no one can have a positive feeling when being left behind in the cold." P4 said AV1 was "cold, physically unpleasant, and mentally distressed."

- On October 27, 2022, P5 told P6 and P8 that on October 25, 2022, P5 saw AV1 sitting "alone" on the toddler playground. P6, P8, and (P13) then spoke to SP1, SP2, P4, P5, P7, and another staff person (P10) about the incident.

- P4 said that P5 notified him/her of AV1 being alone on the playground and P4 brought AV1 to SP1's and SP2's classroom. P4 asked SP1 and SP2 how long AV1 was unsupervised and SP1 and SP2 said "less than five minutes."

- SP1 and SP2 each told P6, P8, and P13 that the morning of the incident was "chaotic" because they had swimming that morning in the community center. After lunch, they decided to take the children outside to the playground to get some "energy out." SP1 and SP2 did not put jackets on the children because it was a "warmer" day and they were only going out for a "few minutes." Once they returned to the classroom, SP1 and SP2 realized that "a child" was still outside and during that time, they saw P4 at the exterior classroom door holding AV1. AV1 was "not upset" and "showed no signs of distress."

- After speaking to staff persons, P6, P8, P13, and a security guard from the community center reviewed video footage of the playground to "confirm" the amount of time that AV1 was outside unsupervised. Video footage showed that around 12:30 p.m., children from SP1's and SP2's classroom went outside for a "few" minutes to run around. The children then went inside while AV1 was left on the playground by "[him/her] self" for "just about five minutes."

SP1 provided the following information:

- SP1 did not recall the date of the incident but said that it was a "very busy day" because there were a "few extra" children in the classroom, including AV1. However, the classroom was in ratio and SP1 thought that there were 11 children in the room. Additionally, it was also a swimming day which was "intense."

- At some point, the children ate lunch and after, had a "ton of energy." Because of this, SP1 and SP2 "let [the children] run around" on the playground. AV1 and the other children were not wearing coats because it was a "quick" run outside. The children "ran in circles" to get their "last burst of energy" out prior to getting ready for nap. SP1 then "called" to the children to come inside and counted as the children were coming in. SP1 did not recall hearing SP2 count and said that s/he sent some children "ahead" to use the bathroom with SP2. SP1 then assisted children to use the bathroom and read a story when SP1 asked SP2 if s/he had AV1. At that same time, P4 and P5 came into the classroom and said that AV1 was left unsupervised on the playground. SP1 and SP2 got AV1 inside and "thanked" P4 and P5. AV1 was not crying but was a "little confused" when s/he returned. SP1 thought that AV1 was confused because s/he was "new" to the facility. SP1 and SP2 then continued getting the children ready for a nap.

- The playground was "pretty secure" but risks to AV1 being unsupervised included AV1 getting hurt, including falling off the climber.

- SP1 was trained to supervise children by lining them up and doing head counts, including during transitions. If there were two staff persons working in a classroom, both staff persons "tried" to do the head counts. The head counts were not documented. However, staff persons knew how many children were present in the classroom from an attendance sheet and "just from counting." There was "no formal process" for adding children from another classroom to the attendance sheet but SP1 "sometimes" wrote a "note" on the bottom of the attendance sheet. Staff persons were to be within sight and sound of children at all times.

SP2 provided the following information:

- SP2 did not recall the date of the incident but said that it was on a "Tuesday" because they had swimming that day. On that date, because of swimming, the children were a "little more energetic than usual." There were also additional children in the classroom, including AV1.

- SP2 did not recall the specific time but thought that s/he and SP1 took the children outside after lunch, because they would have been swimming prior to lunch. At that time, SP1 decided to "run around the playground" with the children. SP2 was "a little bit frustrated" that SP1 decided to go outside "all of a sudden" and that SP1 did not tell SP2 prior to going out. SP1 took a "good portion" of the children with him/her and then SP2 took the remaining children a short time after. SP2 thought that AV1 was "one of the last ones out" with SP2. After running around, they began going inside and SP2 stood by the door to help the children inside. SP2 was the first staff person into the classroom with the children. It was "pretty chaotic" which SP2 also said was "semi-normal" due to the ages of the children in the room.

- Due to SP1 going outside before SP2, SP1 was outside approximately five minutes with some children and SP2 was outside for a "couple minutes" with the remaining children.

- Not "very long" after getting inside, P4 and P5 opened the exterior classroom door and brought AV1

inside. When SP2 saw AV1, SP2 got a "sinking feeling in the pit of [his/her] stomach" that s/he and SP1 made a "terrible mistake." P4 and P5 said they found AV1 sitting on the edge of one of the playground platforms. AV1 looked "content."

- When P4 and P5 returned AV1, SP1 was "exasperated" and said that s/he had "counted" the children. SP2 did not hear SP1 count but said that staff persons "did not always count out loud." SP2 said that s/he had "forgotten" to count the children as they were coming in. SP2 said this may have happened because s/he was the first staff person in and not the last and the "instinct" to count "did not kick in." Additionally, staff persons sometimes had the children line up outside prior to going inside but that was not done on the date of the incident. All staff persons in the classroom were responsible for counting the children.

- SP2 then checked to see if AV1 was cold as it was "not very warm" outside and SP1 and SP2 did not put jackets on the children as they were just going outside "quick" to run around. AV1 did not feel "as cold" as some of the other children (that SP2 helped inside) which was a "relief" as AV1 was "at least not freezing." SP2 thought that AV1 was not as cold as some of the other children due to AV1 being in the second group of children to go outside and therefore, not outside as long.

- Although there were no injuries to AV1, risks to AV1 being unsupervised could have included AV1 falling off the playground equipment. Additionally, AV1 could have gotten "dangerously cold" as it was a "colder day."

- SP1 and SP2 did not document the incident as SP2 said it was a "survival mode day." SP2 felt "so bad" about the incident.

The FM was notified of the incident approximately "a week" after it occurred. It was a "hard conversation" to have" because the incident was "scary." The facility said that they watched video footage of the incident and the FM was told that it was a "relatively short time" that AV1 was unsupervised, which the FM thought was approximately four minutes. The play area was a "gated area" and "very hidden to the outside world." AV1 was not with his/her normal classroom on the date of the incident so from the FM's "perspective," it was "more chaotic than usual." AV1 did not have a history of similar incidents. The FM did not have any other concerns with the facility or with staff persons, including staff persons interactions with AV1.

The *Early Childhood Center Parent Manual 2022-2023 Minnesota JCC* said that children enrolled were "under adult supervision at all times." A staff person was to accompany children whenever they moved to different areas of the facility.

The *Sabes JCC Early Childhood Center Staff Handbook* said that staff persons were to "always" be within sight and sound of children. Each classroom had a clipboard that was used by parents to sign children in and out. That clipboard was to be with one of the staff persons at all times, including on the playground. This was to ensure staff persons had an accurate count at all times. In addition, prior to leaving one space, a staff person was to count the children to ensure it matched the sign in/out sheet and then count the children once they arrived to the new space. Additionally, children were to be in a line and one staff person was to be in the front of the line and one at the end of the line.

Relevant Rules and/or Statutes:

Minnesota Statutes, section 245A.02, subdivision 18 and Minnesota Rules, part 9503.0045, subpart 1, item A, state that "supervision" means a program staff person is within sight and hearing of a child at all times so that the program staff person can intervene to protect the health and safety of the child; and that children are required to be supervised at all times.

Conclusion Allegation One:

Information was consistent that on October 25, 2022, AV1's classroom went outside to the playground with SP1 and SP2. As they were coming in, SP1 said that s/he began counting the children. SP2 said that s/he had "forgotten" to count the children. The classroom then came inside. Around this time, P5's classroom came outside and P5 saw AV1 sitting on the enclosed toddler playground and returned AV1 to the classroom as SP1 relalized AV1 was missing. There were no injuries to AV1. Video footage reviewed by the facility showed that AV1 was unsupervised for approximately five minutes, which was a violation of Minnesota Statutes, section 245A.02, subdivision 18 and Minnesota Rules, part 9503.0045, subpart 1, item A.

Minnesota Statutes, section 260E.30, subdivision 3 states that rather than making a determination of substantiated maltreatment by an individual, the commissioner of human services shall determine that a nonmaltreatment mistake was made by the individual. A nonmaltreatment mistake occurs when:

> (1) at the time of the incident, the individual was performing duties identified in the center's child care program plan;
>
> (2) the individual has not been determined responsible for a similar incident that resulted in a finding of maltreatment for at least seven years;
>
> (3) the individual has not been determined to have committed a similar nonmaltreatment mistake under this paragraph for at least four years;
>
> (4) any injury to a child resulting from the incident, if treated, is treated only with remedies that are available over the counter, whether ordered by a medical professional or not; and
>
> (5) except for the period when the incident occurred, the facility and the individual providing services were both in compliance with all licensing requirements relevant to the incident.

Although AV1 was left unsupervised on the facility playground for approximately five minutes, SP1's and SP2's actions or conduct was determined to be a nonmaltreatment mistake for the following reasons:

> (1) At the time of the incident, SP1 and SP2 were each performing job related duties, as require by the facility's policies, by SP1 counting the children and assisting children with going to the bathroom;
>
> (2) Neither SP1 nor SP2 had been determined responsible for any previous incident that resulted in a finding of maltreatment;
>
> (3) Neither SP1 nor SP2 had been determined to have committed a nonmaltreatment mistake under this paragraph;
>
> (4) AV1 was uninjured and did not require medical care after the incident; and

(5) Except for the period when the incident occurred, the facility, SP1, and SP2 were each in compliance with all licensing requirements relevant to the incident.

The nonmaltreatment mistake to AV1 by SP1 and SP2 was not maltreatment.

It was not 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.)

Allegation Two: *It was reported that AV3 was unsupervised in the facility hallway for five minutes.*

AV3 was approximately two years old at the time of the incident.

P7 said that on an unknown date in the fall of 2022, P7 "heard" through the "grape vine" and through P6 that AV3 was unsupervised for approximately five minutes while being supervised by SP1. On that date, P6 told P7 that s/he found AV3 in the hallway. P7 "heard" that SP1 had assisted AV3 to a bathroom that connected SP1's classroom to another classroom and that AV3 went from SP1's classroom bathroom into the other classroom (which did not have children or staff person's present) and walked out of that room into the hall. There were no injuries to AV3 due to being unsupervised. P7 was told that AV3 was "just hanging out" and "looking around" when s/he was found by P6. P7 had worked with AV3 prior and said that AV3 was "very curious" and "fast." Risks to children being unsupervised in the hallway included children accessing the kitchen. Although the kitchen door was typically shut, AV3 could "probably figure out a way to open the door." In the kitchen, AV3 could have accessed knives. AV3 could have also accessed empty classrooms. P7 did not think that AV3 was "strong" enough to open the doors to go outside or tall enough to open the doors into the community center. There were also construction persons doing work at the facility around the time of the incident.

P3 said that s/he did not see the incident but "heard" from staff persons that on October 25, 2022, AV3 opened the classroom door and walked out of SP1's classroom. Another staff person (who P3 did not identify but who P3 said was working in another room) noticed AV3 "just sitting" in the hallway and walked AV3 back to his/her classroom. P3 heard that AV3 was in the hallway unsupervised for over five minutes. To prevent children from leaving the classrooms, staff persons could shut the classrooms door or "strategically" be near the door. Aside from parents or other people picking up children, there were no other community persons in the hallways.

P4 said that "recently," children in SP1's classroom opened the classroom door "a lot" and went into P4's room. However, SP1 was aware and "chased" those children.

P5 said that at times, children ran out of their classroom to get something out of their locker. However, it was never more than one "minute" that a child was not supervised. P5 had to stop "a lot" of children from trying to go into the hallway "by themselves," but P5 was not aware of a child being unsupervised in the hall for five minutes.

P1, P2, and P6 were not aware of any child being unsupervised in the hall, including up to five minutes. However, P1 and P2 said that children ran out of SP1's classroom, including an alleged victim (AV5), and P1 said it was a "lot." P1 and P2 said that "every time" it happened, SP1 was aware and would go out and get the children. P1 said that SP1 typically had his/her classroom door open in the morning during arrival but closed during the day. According to P1, risks to children being unsupervised in the hallway included children accessing the community center via "secured" doors, getting hurt by climbing on things, or "falling into the toilet."

SP2 said that children "liked" to leave the classroom, including opening the classroom door. SP2 did not know how long a child was unsupervised but said it was "not very long" and that staff persons "go and get [the children]," including that AV5 liked to open the door and "bolt." Staff persons were trying to figure out "strategies" to try and prevent this from happening, including guiding children away from the door and keeping the door closed, which AV5 could open. There were also a "couple" times that AV3 left the room and staff persons did not "notice right away" but SP2 said it was only a "few seconds." SP2 was not aware of any incidents where a child was unsupervised in the hall for five minutes. There were no injuries to the children being in the hall unsupervised. However, risks to children being unsupervised in the hall included children climbing on "buggies" and getting injured. There were also construction persons in the building that sometimes walked through the halls of the facility.

SP1 said that his/her classroom had an "issue" where children ran out of the room while staff persons were "occupied." However, when this occurred, staff persons, including SP1, "ran after" the children. There were no injuries to children because of this. Staff persons closed the classroom doors but some children opened them. Because of this, the facility was purchasing "child locks" for the doors. SP1 was not aware of any child being unsupervised in the hall, including for five minutes, and said that staff persons were always "near" the children. Risks to children being unsupervised in the hallway included children being able to open doors, including to the kitchen. Children may also be able to access things that were not age appropriate. There were also construction people going "back and forth."

Conclusion Allegation Two:

Although P1, P2, P4, SP1, and SP2 provided consistent information that children would leave SP1's classroom and go into the hallway, information was consistent that staff persons, including SP1, were aware the children had left and immediately followed. These children were unsupervised between "seconds" and not more than one "minute." Staff persons were also working on ways to prevent children from leaving the room. Additionally, although P7 and P3 heard that AV3 was unsupervised in the hall for five minutes or more, P1, P2, P6, and SP1 were not aware of any child being unsupervised in the hall, including up to five minutes. Therefore, there was not a preponderance of the evidence that there was a failure to supply care o or a failure to protect a child, including AV3, from conditions or actions that seriously endangered their physical or mental health when reasonably able to do so.

It was not 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 and/or 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).

Allegation Three: *It was reported that there were multiple concerns with SP1's interactions with children.*

AV2 was approximately 20 months old at the time of the alleged incidents. AV4, AV5, and AV6 were approximately two years old at the time of the alleged incidents. AV7, AV8, AV9, AV10, and AV11 were approximately two and a half years old at the time of the alleged incidents.

P3 provided the following information:

- P3 had "several" concerns with SP1, including the safety of the children while in SP1's care. In approximately May or June 2022, P3 was working with SP1 in one of the toddler classrooms. The classroom was returning from a walk outside and the children were walking in a line, with SP1 in the front of the line. They were entering the facility via a door and the children were waiting on a rug in the entryway so that SP1 could open a second door. However, an alleged victim (AV2) was not "paying attention" and "did not stop" walking and SP1 "angrily" said to AV2, "I said no." SP1 then "extended" his/her arm and pushed AV2 who fell into another alleged victim (AV8). Both AV2 and AV8 fell to the ground and AV2 fell on top of AV8. All the other children present "froze," were in "shock," and were "afraid" of SP1. Everything was "okay" with AV2 and AV8 and there were no injuries to them. SP1 "proceeded to walk away as it nothing happened."

- P3 had not seen SP1 "push" a child prior but had seen SP1 "stop" a child by putting one hand out. P3 said that SP1 should have told AV2 that s/he needed to "stop and wait" on the carpet.

- The incident with AV2 and AV8 "sat heavy" with P3 so the following day, P3 wrote an email to P6, P8, and a supervisory staff person (P9). There was also video footage of this incident and P3 believed that the supervisors viewed the video footage.

- SP1 also yelled at children when "frustrated" and had "no patience" with the children. P3 described SP1 as "abrupt" with "several children" and said that SP1 "did not want to be bothered." SP1 also displayed "favoritism" towards some children and was "mean" towards others. P3 would not feel comfortable having SP1 working with his/her own children.

- P3 told P6 and P9 about these concerns. P6 and P9 then asked P3 if P3 and SP1 could "talk about things" which "seemed to work" for a "few days" and then it was "back to the old routines." Additionally, SP1 was "pushed from room to room." P3 had worked in a childcare setting for "over 30 years" and "never" felt that his/her concerns were not "heard" by supervisory staff persons, such as what was occurring at the facility.

P1 provided the following information:

- P1 said that staff persons "never know what mood [SP1] will be in." SP1 was "frustrated or overwhelmed" when there was a "big group" of children. P1 also described SP1 as "annoyed," "irritated," and "short tempered" with the children. P1 provided an example and said that SP1 was "kind of snappy" in his/her "tone" and would take away a toy from a child and tell the child that they were "done with that." However, if parents were around, SP1 would "switch" and be "super nice" and "try to do everything by the book."

- P1 had also seen SP1 "grab [a child] firmly" or "snatch them up really firmly" when the child "did not even know it would happen." This "startled" the children. SP1 also "sat [children] down really quickly" or "firmly" and those children would look "really surprised" or become "sad" and cry. P1 did not recall any specific child's names but said that it happened a "lot." P1 did not know if SP1's interactions would be "enough to hurt" a child but said that when s/he saw these things, it made him/her "uncomfortable." P1 never saw injuries to children as a result of SP1's interactions.

- P1 would not feel comfortable having his/her own children in SP1's classroom due to these concerns. However, P6's own children, including (AV4), were in the classroom and when P6 was nearby, SP1 was

the "perfect teacher."

- P1 was not aware of SP1 pushing a child. P1 only heard SP1 yell at a child if something was not "safe," including to stop a child from biting another child.

- Staff persons were trained to interact and speak to children "calmly." Staff persons could step out of the room or ask another staff person for help when needed. There were times when SP1 was having a "hard time" and told another staff person in the room that s/he could not "deal" and would "walk away from the situation."

- P1 said that "all" staff persons who worked with SP1 expressed concerns with SP1. Supervisory staff persons, including P13, were also aware because P1 and P4 emailed "multiple" examples of concerns they had when they worked with SP1. P1 was not aware of anything being done because of the concerns and said that SP1 "keeps getting passed along" to different teachers.

- P1 was not aware of anyone who would provide inaccurate information regarding SP1 or anyone who would have reason to get SP1 in trouble.

P2 and an email P2 sent to P6 and P8 dated September 30 (no year listed), provided the following information:

- P2 said that SP1 was "rude and abrupt" with children. SP1 was also "condescending" and would "roll" his/her eyes if children did not listen. SP1 would also "scream" at children. SP1 was "very loud and stern" and the classroom next door heard SP1 and asked if "everything was okay." P2 did not think that children were "okay" because they were "being screamed at all day." SP1's "tone" was "never" "nice." SP1 was "frustrated" and took out his/her "anger" on children.

- SP1 did not do the aforementioned things to all children and there were some children who SP1 was nice to "all the time." SP1 displayed these negative behaviors/interactions with children who had "more trouble listening." SP1 was "expecting two-year old's to be four," including AV3. SP1 was "constantly frustrated" with AV3 who was the "youngest" in the group. SP1 was "more harsh" with the "younger" children because they could "not meet up to [SP1's] expectation." SP1 was "not very nice" "unless a parent or director" was nearby and then SP1 was the "nicest human anyone met."

- Additionally, SP1 would "grab" children's hands during mealtimes, including to "force feed" children, including AV4 and AV5. The children would then "spit out" the food and SP1 would "yell at them." P2 told SP1 that s/he should not "act like that" but SP1 continued to "force" feed children. P2 did not think that a child was at risk of choking due to SP1's interactions but said that a child "potentially" could have vomited or developed a "very unhealthy relationship with food."

- SP1 also had a "rule" that if children wanted "seconds" of lunch or snacks, they needed to "clear [their] whole plate first." This was not a facility rule and P2 told SP1 that it was "not appropriate" for SP1 to do so because they were "two years old" and it was "normal" for them not to "try" all their food.

- AV5 was a "huge flight risk" and was "constantly running" out the door of both the exterior classroom door and the classroom door into the hallway. SP1 then "screamed" at AV5 how "running away" was

"not okay."

- On another occasion around "late" September or early October 2022, an alleged victim (AV6) had just left the bathroom and was "standing" near the bathroom exit. SP1 was trying to leave the bathroom and was "very flustered." SP1 could have "very easily" walked around AV6 but instead, SP1 "pushed" AV6 "down" and AV6 "knocked" his/her head on the diaper table. AV6 was "screaming and crying." P2 told SP1 that s/he "just pushed [AV6] down" and SP1 "rolled [his/her] eyes." AV6 was not crying prior to the incident. P2 was not aware of any injuries to AV6 and believed that AV6 cried for "about five minutes." P2 "believed" s/he told P6 about this.

- At some point, P3 also told P2 that s/he saw SP1 "push" AV2 and that "nothing was done."

- P2 had also seen SP1 "kick [not hard]" or "push" children with his/her foot if they were not going "fast enough" to the lunch table. There were injuries to children because of this and staff persons should "absolutely not" do this.

- P2 told P6 and P8 the concerns "multiple times" and emailed them a "huge list of every behavior and action" that P2 saw. P8 said that s/he would "take care of it" and talk to SP1 but then no "follow up" happened. P2 also told P6 about the incident where SP1 "force fed" AV4 and AV5 (P2 told P6 on the same date it occurred) but "nothing happened." However, P6 and P8 told P2 that they could move P2 to another classroom, which P2 thought was a "dumb decision." P2 was "very frustrated."

- P2 thought that SP1 continued to work at the facility because P6 "really loved" SP1 and "covered up" for SP1. Additionally, despite P2 telling P6 about the concerns, P2 did not think that P6 witnessed any of them due to SP1 being a "completely different person" around supervisory staff persons such as P6 and parents.

- P2 thought that SP1 needed to be "as far as possible" from children. P2 would not feel comfortable having SP1 as his/her child's teacher due to SP1's interactions.

- P2 was not aware of anyone who would provide inaccurate information regarding SP1 and said that staff persons "all want what is best for the kids."

P7 provided the following information:

- P7 said that in approximately 2016, an alleged victim (AV15) in the infant room fell asleep in his/her highchair. P7 was going to take AV15 out of the highchair and put AV15 in his/her crib when SP1 told P7 that AV15 was not sleeping and to "watch this." SP1 then took a broom and "slammed" the broom against AV15's highchair. AV15 "jumped and screamed" and was "startled" and then SP1 began "laughing hysterically." P7 asked SP1 "what [s/he] was doing," and then P7 "blocked" SP1 by standing in front of AV15's highchair. P7 then picked up and calmed AV15 and put AV15 in his/her crib where AV15 fell asleep. P7 was "appalled" by the incident.

- A couple months after the incident with AV15, AV15 again fell asleep in his/her highchair. SP1 again said that AV15 was not asleep. SP1 then took a piece of food and "shoved" it into AV15's mouth and said that AV15 was not sleeping but was "eating." P7 told SP1 that AV15 could "choke" and P7 "swept" the food out of AV15's mouth and took AV15 to his/her crib. AV15 did not wake during that incident. However,

putting food in a "sleeping child's mouth was a huge hazard" as a child could "inhale and choke." P7 was "quite upset" about the incidents with AV15 so P7 documented both incidents and reported it to a former supervisory staff person (P14) but "no action was taken." Whenever P7 told P14 about concerns with SP1's interactions with children, P14 would "always make excuses" for SP1 and say that SP1 was "young and learning." It was "concerning" that supervisory staff persons did not do anything. P7 told P14 that SP1 was "dangerous" and that s/he did not "trust" SP1 with the children.

- A times, P7 had seen SP1 "handle" children "roughly" and said that it was "rough enough for [the children] to fall." If a child was lying on the floor, SP1 grabbed the child by one arm and picked them up. P7 told SP1 not to pick children up "that way" and SP1 would then "drop" the child who would "fall" onto the floor and cry. P7 did not recall which children SP1 did that to but said that it occurred two to three times. P7 was not aware of any injuries to these children.

- There were also times when SP1's classroom was outside and SP1 would have his/her back to his/her class or would be coloring on the sidewalk, on the phone (which P7 said was a "lot,") or talking to other staff persons. SP1 was "not paying attention" to the children. At some point, a child was running and tripped on a ball and landed "flat" on his/her back. This child was crying and SP1 "dismissed" the child. P7 told SP1 that the child "just fell and really hit [his/her] head" and SP1 said, "Oh. [The child's name] will be fine." P7 said that the child "really could have hurt [his/her] head" and SP1 had "no compassion."

- SP1 had children become "so dependent" on him/her, including an alleged victim (AV16). AV16 followed SP1 around and SP1 "loved up" on AV16 but then "one day," SP1 was "done with [AV16]." P7 provided an example that AV16 went to give SP1 a hug but SP1 told AV16, "No," and then SP1 "moved [his/her] hand" in a gesture like "go away." SP1 told AV16 that s/he was "bothering [SP1]" and then SP1 turned away from AV16. P7 said this was "so hard to watch" because AV16 did not understand what s/he had done wrong. However, during pick up when AV16's parents were around, SP1 "loved [AV16] up" but later, SP1 "wanted nothing to do with [AV16]."

- Around November 2022, while on a walk, P7 heard SP1 "scold" a child who ran over to say hi to his/her sibling who was with another classroom. SP1 "really popped [this child's] balloon" as s/he was "so excited" to see his/her sibling. P7 said that children were encouraged to say hi to siblings and that parents enjoyed having siblings at the same school.

- At some point, P3 was "really upset" and told P7 that SP1 pushed a child. P7 told P3 to document it and then tell P6 and P9.

- Children were always initially "really excited" to be in SP1's classroom because SP1 made things "sound" fun. However, SP1 later picked out his/her "favorite" children, including AV4, and then "ignored the rest." P7 agreed that AV4 was a "great kid" but said that some children were "more difficult than others" and that staff persons had to "spend more time to figure [those children] out."

- P7 did not know why supervisory staff persons, including former supervisory staff persons, did not do anything regarding the concerns. It was "very frustrating" that nothing was done. However, P7 did not think that a lot of persons were aware of the concerns as SP1 had a "great personality" in front of others,

  including parents. SP1 told parents that their "kids are the greatest" but later, SP1 would "turn away" from their children and say that s/he "did not like them" or that they "bothered" him/her.

- P7 would "absolutely not" feel comfortable having his/her own children, "grandchildren," or "neighbors children" in SP1's classroom. P6's own child (AV4) was in SP1's classroom and P7 thought that P6 was a "little blinded" by SP1. P7 did not know why P6 thought that SP1 was "such a great teacher" and thought that they might have had a "friendship" instead of a "professional relationship."

- P7 said that there was no reason not to believe what other staff persons said about SP1 as P7 had "seen it with [his/her] own eyes." SP1 had worked in "every classroom" as no staff person wanted to work with SP1 due to his/her "treatment of children." At some point, SP1 told P7 that the "only reason" s/he worked at the facility was because the "money was so good" and SP1 "did not have to work."

P4 and an email P4 sent to this investigator dated December 3, 2022, provided the following information:

- P4 said SP1's interactions with children "depends on [SP1's] mood" and if supervisory staff persons or parents were around. SP1 also had "favorite" children. SP1 would get "mad" if a child did not do art the way SP1 wanted. However, the children were "two." SP1 "yelled at [children] constantly." P4 also described SP1 as "mean" and "unreasonable" with the children. It was "worrisome" having SP1 around "innocent children."

- P4 had been at the facility for 16 years and said that SP1 had "pretty much" always been like that. Staff persons only worked with SP1 a year or two because "no one can handle" SP1. When staff persons expressed concerns to supervisory staff persons, P6 moved SP1 to another classroom and said it was the "first time" s/he heard of the concerns. P4 did not know why SP1 continued working at the facility but said that P6 "favored" SP1. Supervisory staff persons "failed to take action" on these concerns but P4 hoped that because of this investigation, SP1 could no longer "hurt" the children both "physically and mentally."

- P4 would not feel comfortable having his/her own child in SP1's classroom. However, P6's own child (AV4) was in SP1's classroom but SP1 treated AV4 "differently" and was SP1's "favorite" child.

P5 provided the following information:

- P5 did not work with SP1 a "lot" and never saw SP1 "maltreating a child." However, P5 heard that a "lot" of staff persons, including P2, had concerns with SP1. P5 did not think that any staff person was "against" SP1 or trying to get him/her in trouble by "any means." P5 trusted what the other staff persons said about SP1 "more" than s/he "trusted [SP1]." P2 told P5 that s/he talked to supervisory staff persons "many times" about the concerns and they did not do "anything about it." P5 thought that SP1 had a "lot of immunity" at the facility. Additionally, the facility was short staffed and may have needed to keep SP1 as a staff person.

- P5 described SP1 as "very caring and loving" and said that SP1 hugged children "a lot." P5 had seen SP1 become a "little frustrated" but it was "never something for [P5] to be worried about." P5 described SP1's frustration as that SP1 would "push" a child's back when walking and tell them to "keep walking" but said that it was "gentle." This was a "little red flag" because the children were "still so young." SP1 should have waited for the children to walk. On a "couple" of occasions, P5 also heard SP1 "raise" his/her voice while s/he was "frustrated," which P5 "sometimes" did too. SP1 also "expected a lot" from children, including that their artwork was to be "impeccable." SP1 wanted to "control" the "environment,"

including children's artwork, and SP1 wanted the children to "behave a certain way."

- P5 would "never" put his/her own children in SP1's classroom and said that it was "hard" to feel "comfortable" with SP1.

SP2 provided the following information:

- SP2 said that SP1 could be "super amazing, friendly, and engaged" with the children. However, SP1 also set "high standards" for children and did not have "patience" with them when they could not meet those expectations. The children were two years old, yet SP1 expected more from them than what was typical. This was not "bad," but SP1 could "ease off a bit." SP1 also had "zero tolerance," including when children "dumped" buckets of toys, even during playtime. Children had to clean up the "entire bucket" before they could "move on." SP2 was "most concerned" about SP1's "lack of flexibility" with the children.

- SP2 said that the "atmosphere" in the classroom when SP1 worked was that so the children could not "relax" or be "themselves." SP2 also had concerns with SP1's "tone of voice," including that SP1 was "stern." SP1 "scolded" the children to a "certain degree," including AV6 who had "trouble" sitting and would get out of his/her seat during lunch or snacks. SP1 "scolded" AV6 "a lot." SP2 described this as a "raised voice" or "yelling." SP1 also had a "very exasperated voice," including when children were "misbehaving." SP2 said that the children's reactions to SP1 "varied" and sometimes they listened and sometimes they did not.

- In approximately September 2022, SP1 asked an alleged victim (AV7) to clean up but AV7 did not "listen" and went and did something else. Without saying anything, SP1 went to AV7 and "grabbed" AV7's hands and "carefully moved" AV7's hands to put the toys away on the shelf. This "bothered" SP2 and made him/her uncomfortable so SP2 told P6. SP1 took it "too far" because AV7 had moved on and was not "thinking about the toy anymore." AV7 went "along with it" and did not cry.

- When this investigator asked if children were ever "scared" of SP1, SP2 said, "yeah." AV4 (who was P6's child) "pooped" "every 10 minutes" and SP1 was "very impatient" with AV4 because of this. P6 did not have any concerns with SP1 but SP2 thought this was because P6 "did not see everything." However, SP1 could also be an "amazing teacher when [s/he] was not all stressed out." Additionally, for the "most part," the children "loved" SP1.

- SP2 was not aware of any injuries due to SP1's interactions. SP2 was not aware of SP1 pushing a child, including AV2. Staff persons were trained to not yell, grab, pull, or push a child. Staff persons were to "guide" children.

- A couple of times during the interview, SP2 told this investigator that s/he "did not want to get [SP1] in trouble" because s/he had to continue working with SP1.

- SP2 would not feel comfortable having his/her own children with SP1. Additionally, SP2 "heard" a staff person (P12) state that s/he did not want his/her child in SP1's classroom due to SP1's interactions. SP2 was not aware of any reason why staff persons would say things about SP1 that were not true.

P6 provided the following information:

- At some point, P3 told P6 that SP1 pushed AV2 in the entryway and that AV2 fell to the floor. P6 did not see the video footage of the incident but said that P8 and P9 saw it. P8 and P9 said that it looked like AV2 had "tripped" and P6 said that the incident "ended up not being anything." P6 did not think the video footage had sound. P6 did not know why P3 thought that SP1 pushed AV2. There were no injuries to AV2. P3 did not tell P6 any other concerns aside from concerns with SP1's "attendance."

- Other staff persons, including P1 and P4, expressed concerns with SP1's interactions with children "here and there." When that occurred, P6 would "connect" with SP1. P6 could not think of an example of P1's and P4's concerns and said it was a "long time ago" and was "nothing serious." If P6 saw concerns, s/he would "probably not" have SP1 working at the facility.

- P6's own children, including AV4, were in SP1's class. P6 observed "pleasant interactions" and P6 "trusted" SP1. P6 described SP1 as "passionate" and "dedicated." P6 would not put his/her own children in "harm's way." P6 had not heard SP1 yell at children. Children did not appear scared of SP1 and the children "seemed to love" SP1.

P4 provided emails of concerns that had been sent from P1 and P2 to supervisory staff persons as noted below:

- An email dated January 23, 2020, sent from P1 to P4, P8, P9, and P14 provided the following:

    - On January 22, 2020, around 9 a.m., P1 walked into his/her classroom and saw an alleged victim (AV9) on the floor near the bathroom. AV9 was crying and did not have any pants or underwear on. SP1 was also in the classroom but was working on an art project and had his/her back towards AV9. P1 asked SP1 "what was going on" with AV9 and SP1 told P1 that AV9 was not "using [his/her] words" and that SP1 "did not know how to help" AV9. P1 then asked AV9 if s/he had an "accident" and AV9 said, "Yes." P1 then asked AV9 to put on his/her underwear first (before his/her pants) and assisted AV9 to do so. SP1 then said to AV9, "Oh good. You are talking. I can help you now." Around this time, another staff person (P16) came into the classroom and asked what was wrong with AV9. SP1 again said that AV9 "would not talk so I guess [AV9] does not want help." P16 then gave AV9 a hug and asked AV9 if s/he needed help and AV9 said that s/he did. P16 then helped AV9 finish getting dressed.

    - P1 also told P4, P8, P9, and P14 that on January 22, 2020, SP1 said that "all of the kids had been awful all morning" and "especially this one." SP1 then lifted his/her foot and put it on the back of an alleged victim's (AV10's) head and pushed AV10 with his/her foot. AV10 fell forward and then looked "back" at SP1, who "walked away." (Note: There was no indication if AV10 received any injuries because of this).

    - P1 also said that SP1 "always singles out the kids [s/he] does not like and punishes them." At some point around January 23, 2020, after lunch, SP1 was reading a book but was "so annoyed" by the children. SP1 told the children that if they "move" or made a "sound," the children were "going to [their] cot" and that they "did not get to read books." SP1 then proceeded to tell five or six children to go to their cots in a "harsh and mean voice." P1 said that the children were toddlers so this was an "unrealistic expectation." P1 said that SP1 was "constantly" using

      "negative reinforcement" and "threats" to the children. SP1 was only "positive" if a supervisory staff person was nearby.

- P1 also said that SP1 was "constantly mean" to an alleged victim (AV11), including on January 22, 2020. On this date, P1 and SP1 had children "running" on a ramp but then some of the children began climbing on a nearby bench. Because of this, SP1 and P1 decided to "head to the elevator" to go on a walk. However, SP1 was trying to "punish" children who were climbing on the bench. SP1 asked P1 which children were on the bench and P1 said that s/he was "not sure." SP1 then asked P1 if AV11 had been on the bench. P1 said that if s/he would have said yes, then SP1 would have made AV11 walk up the stairs (with SP1) instead of taking the elevator with the rest of the group.

- On another occasion, SP1 did not want to assist another teacher. SP1 then began crying and "slammed" the classroom door, which P1 said "startled" both staff persons and children.

- An email dated September 18, 2019, sent from P1 to P4 and P8 provided the following:

  - SP1 "forced" food into children's mouths. This included at some point, SP1 "forced" an avocado into an alleged victims (AV12's) mouth. AV12 then spit it out and said that s/he did not like it. SP1 then told AV12 not to spit out the food and then SP1 put the food back into AV12's mouth, which made AV12 "puke." P1 said that and P9 and P14 were aware of this.

  - P1 also told P4 and P8 that SP1 withheld food from the children during snack and lunch.

  - P1 told P4 and P8 that SP1 had "very little patience" for children of this "age" or children with "challenging behavior." If a child did not understand something, SP1 said to the children, "You guys should already know how to do this by now," in a tone that was "mad" and "mean." SP1 was "constantly" doing personal stuff on the computer or phone and "not watching" the children. SP1 would then get "mad" when the children took out toys. SP1 also made children stay on their cots until "exactly" 3:30 p.m., even if they woke up earlier.

  - P1 also said that SP1 was "always rough" with children that SP1 "openly" said that s/he "did not like" or "can't stand." This included that SP1 would "yank" or pull their arms "really hard" or that SP1 "puts them on the rug very hard or in their chairs." P1 said that occurred "every day," especially when SP1 was in a "bad mood." On one occasion, an alleged victim (AV13) hit his/her head during this and began crying and saying, "Owie." If a child was playing with a puzzle piece away from the puzzle area, SP1 "yanked" it from their hand and said, "I don't like that" instead of asking the child to bring the puzzle piece back to the puzzle area. A lot of times, the children would start crying, which P1 thought was because they did not understand why SP1 took the puzzle piece from them.

- An email dated October 18, 2022, sent from P2 to the general facility email (it was unknown who received the email), said that at some point in the "summer," SP1 was drawing Sesame Street characters with chalk. SP1 yelled at the children if they "touched" or took SP1's chalk. If a child asked for help, including with getting dressed, SP1 would "yell directions" at the child instead of showing them how to do something or encouraging them to try. SP1 also set "inappropriate" expectations for the children and was "constantly screaming" at them for not "meeting [his/her] expectations," even though the children were "doing normal toddler things." SP1 yelled at children instead of modeling appropriate behavior. SP1 would "flip a switch" and stop the negative behavior when a supervisory staff person or parent

entered the room. SP1 would also "throw" kids into an empty part of the classroom by themselves when they "can't follow directions." SP1 became "frustrated" when children, including AV7, pooped in a "fresh diaper." SP1 also "snatched" toys from children when they were not using it the way SP1 "wanted them to." SP1 was "rough" with an alleged victim (AV14), who had recently gotten a cast off. If they children were "too crazy" prior to nap, SP1 would "send" them to their cots without checking their diapers. SP1 also force-fed children and then became "mad" when they spit out the food. SP1 yelled at children for not finishing their drinks and would not let them leave the table until their drinks were finished. SP1 also threw away a child's lunch or snack "entirely" if a child was not eating it the way SP1 "wanted them to." Children would ask for more drinks or food and SP1 would "stare at them" without "saying a word." Some days, SP1 also did not give seconds until the child's "entire plate" was empty.

P8 provided the following emails of concerns that s/he received from staff persons over the years regarding SP1, including an email regarding the facility's response:

- On May 10, 2022, P3 emailed P6, P8, and P11 stating that on May 9, 2022, P3 and SP1 were going inside with their class after a "brief" walk around the building. SP1 was in the front of the line and P3 was in the back. Typically, after the children entered the first set of doors (in the entryway), the children stopped on a rug and "froze" until all the children were inside. On this date, after entering the first set of doors, some of the children were "wiggling" and moving around. SP1 opened the second set of doors as s/he was telling the children to "freeze" but some kept moving. P3 then heard and saw SP1 say to an alleged victim (AV2) to, "Stop [name of AV2]." At the same time, SP1 "pushed" AV2, causing AV2 to "knock" into AV8, which then caused AV8 to fall to the floor (Note: P3 told this investigator that both AV2 and AV8 fell to the floor). P3 then helped AV8 up and asked if s/he and AV2 were okay (Note: P3 did not indicate in the email how AV2 or AV8 responded or if there were any injuries). SP1 then proceeded into the facility without "another thought of this situation."

- On May 23, 2022, P8 and P9 met with P3 to discuss the incident (Note: P8 said that s/he was out of town and not able to meet sooner). P8 and P9 then looked at video footage but did not see SP1 push AV2. P8 said that s/he and P9 each thought that the video footage showed that it looked like AV2 was falling as s/he was walking into the building and there was a "domino effect." (Note: P8 told this investigator that the facility no longer had this video footage because it only saved for 10 weeks and DHS was not made aware of the incident until approximately October 25, 2022).

- P8 and P9 then met with SP1 to discuss the incident. SP1 denied pushing AV2 and said that s/he was "trying to prevent [AV2] from fall[ing]." SP1 was "verbally warned" that s/he needed to be "mindful" of where his/her "hands" were when entering a small space and when "handling" children. SP1 was also told to communicate with his/her co-worker's when "things like that" were happening because they could be "seen as being something" they were not.

- On October 26, 2022, P4 emailed P8 stating that s/he was "very concerned for the safety" of the children while "under" SP1's care. This included that SP1 was "very rough" with the children. SP1 also "mentally abused [the children]" and made children feel "bad" about themselves. P4 also told P8 that in the fall of 2019, when P4 worked with SP1, SP1 expected the children, who had just turned two, to be at the "same level" as children who were three and four years old, including with art projects. On October 27, 2022, P8 responded to P4's email and said that it was "troubling" and that s/he would "investigate." P8 told P4 that s/he "greatly appreciated" P4 reaching out to him/her and "advocating" for the children. P8 told P4 that s/he would "be in touch."

SP1 provided the following information:

- SP1 described him/herself as "kind and gentle." SP1 worked with the children "where they were at" and discussed their "feelings." SP1 said that s/he had been told that s/he had "magic powers" as the children "loved" him/her. Children also "fought" over SP1's attention. SP1 did not know why someone would have concerns with his/her interactions with children.

- At some point around May 2022, P3 "accused" SP1 of pushing a child which did "not happen." Additionally, supervisory staff persons looked at video footage of the incident which "showed" that SP1 did not push a child. SP1 said that s/he put his/her arm out as one child was coming inside to protect another child so that they were not "clobbered" and while SP1 had his/her arm out, a child "bounced off" SP1's arm. SP1 denied pushing any child. However, at some point, SP1 said that s/he "knocked" a child over with his/her "butt" but had not done anything "purposeful." SP1 was not aware of any other staff persons or parents having concerns with his/her interactions. Additionally, P6's and P18's children were also in SP1's classroom and P6 and P18 had not expressed any concerns.

- At some point, SP1 "needed" to use a "loud voice" with the children but later "apologized" to the children for doing so. SP1 did not recall when this occurred but said that it was with a "small group" of children.

- SP1 said that it was a "stressful" time because the facility was understaffed. If SP1 needed a break, s/he called another teacher or his/her supervisor and told them that s/he needed a break.

The *Early Childhood Center Parent Manual 2022-2023 Minnesota JCC* said that the "goal" of the facility was to make children feel "safe, happy, and comfortable" throughout the day. Positive techniques for children's behaviors were "always" used at the facility. Staff persons were "prohibited" from rough handling, shoving, kicking, hitting, and pinching children. Staff persons were not to subject a child to emotional abuse including shaming, or language that threatened, humiliated, or frightened a child.

The *Sabes JCC Early Childhood Center Staff Handbook* said that prohibited actions included any action that put the children at risk or caused harm to a child. Staff persons were to respect the dignity of children in their interactions. Staff persons were to be "warm and nurturing." Staff persons were to use "clear, respectful, and positive verbal communication" with children. Corporal punishment, the use of verbal or emotional threats, and shaming or name calling was "never" used. Any such behavior by any staff person was cause for immediate suspension and/or termination.

The *Child Care Center Risk Reduction Plan 2022-2023* said that children were never to be dragged, swung, or pulled by their arms to prevent the dislocation of children's elbows or shoulders.

Relevant Rules and/or Statutes:

Minnesota Rules, part 9503.0055, subpart 1, item A, states that the license holder must ensure that the policies and procedures are carried out. The policies and procedures must ensure that each child is provided with a positive model of acceptable behavior and provide immediate and directly related consequences for a child's unacceptable behavior.

Minnesota Rules, part 9503.0055, subpart 3, item A, states that the license holder must have and enforce a policy

that prohibits the following actions by or at the direction of a staff persons: Subjection of a child to corporal punishment, which includes, but is not limited to, rough handling, shoving, hair pulling, ear pulling, shaking, slapping, kicking, biting, pinching, hitting, and spanking.

Minnesota Rules, part 9503.0055, subpart 3, item B, states that the license holder must have and enforce a policy that prohibits the subjection of a child to emotional abuse. Emotional abuse includes, but is not limited to, name calling, ostracism, shaming, making derogatory remarks about the child or the child's family, and using language that threatens, humiliates, or frightens the child.

Conclusion Allegation Three:

A. Maltreatment:

P1, P2, P3, P4, P5, P7, and SP2 each provided information that they observed multiple different physical interactions SP1 had with children that caused them concern. P1 stated that SP1 "grabbed" a child "firmly" or "snatched them up really firmly." P1 had also seen SP1 sit children down "really quickly" or "firmly." When SP1 did these things, children cried. P2 said that that SP1 "grabbed" children's hands during meals, including to "force feed" the children. P1 and P2 had also seen SP1 "push" children with his/her foot, including if they were not going "fast enough." P3 stated that s/he also saw SP1 push AV2 and P2 had seen SP1 "push" AV6 down causing AV6 to hit his/her head and was "screaming and crying." P7 said that SP1 handled children "roughly," including that SP1 grabbed a child by one arm to pick them up. When P7 told SP1 not to do that, SP1 then "dropped" the child who would begin crying. This occurred on two to three occasions but P7 was not aware of injuries.

SP1 described him/herself as "kind and gentle" and denied pushing any child. Regarding the incident with AV2, SP1 said that s/he had his/her arm out and AV2 "bounced off" his/her arm.

P1, P2, P3, P4, and SP2 also had concerns regarding either SP1's tone of voice and/or verbal interactions with children. P1 described SP1 as "mean," "annoyed," "irritated," "frustrated," "overwhelmed," "snappy," and "short tempered" with the children. P2 described SP1 as "rude," "abrupt," and "condescending" towards the children. P3 said that SP1 spoke "angrily" to AV2 and was "mean" towards other children. P3 also described SP1 as "frustrated," "abrupt," and that s/he had "no patience" with children. P4 described SP1 as "mean," and that SP1 would get "mad" at the children. P2, P3, P4, and SP2 each stated that SP1 either "screamed" or "yelled" at the children. P7 had witnessed that when AV15 feel asleep in his/her highchair, that SP1 took a broom and "slammed" it against AV15's highchair, causing AV15 to "startle" and "jump and scream." P7 had also seen SP1 "shove" food into AV15's mouth while s/he was sleeping. P7 described SP1 as "dangerous."

SP1 said that s/he worked with the children "where they were at" and discussed their "feelings." SP1 said that s/he had been told that s/he had "magic powers" as the children "loved" him/her. At some point, SP1 "needed" to use a "loud voice" with the children but later "apologized" to the children for doing so.

Although P6 did not witness any concerns regarding SP1's interactions with children and had his/her own child in SP1's classroom, given P6's role at the facility, P6 did not watch SP1's entire workday or work directly with SP1 in the classroom for any extended length of time. Additionally, information was consistent fromP2, P4, and P7 that SP1 did not display the behaviors when supervisory staff persons, such as P6, or parents were nearby. Therefore, it was reasonable that P6 may not see any concerning interactions.

Although SP1 denied the allegations, SP1 had reason to minimize his/her interactions for fear of repercussion and there was no information provided to discredit the accounts of the incidents provided by P1, P2, P3, P4, P5, P7,

and SP2 and their descriptions of SP1's physical and verbal interactions with the children were similar in nature. Although there were no known injuries to children, SP1's verbal and physical interactions with children were inconsistent with the standards of a professional caregiver in a facility licensed by the Department of Human Services and were violations of Minnesota Rules, part 9503.0055, subpart 1, item A; and Minnesota Rules 9503.0055, subpart 3, items A and B; and a violation of facility policies and procedures, including the facility's *Early Childhood Center Parent Manual 2022-2023 Minnesota JCC*, the *Child Care Center Risk Reduction Plan 2022-2023*, and *Sabes JCC Early Childhood Center Staff Handbook* policy. Therefore, there was a preponderance of the evidence that SP1's repeated actions including grabbing children, pushing children, and screaming/yelling at children were not accidental and were a failure to supply each child with reasonable and necessary care, a failure to protect each child from conditions or actions which seriously endangered their physical or mental health, and threatened injury to each child.

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).

It was determined that physical abuse occurred ("physical abuse" means any physical injury, mental injury, or threatened injury, inflicted by a person responsible for the child's care on a child other than by accidental means. "Threatened injury" means a statement, overt act, condition, or status that represents a substantial risk of physical or sexual abuse or mental injury).

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.

SP1 received training on the Reporting of Maltreatment of Minors Act and on the facility's policies and procedures, including behavior guidance and the risk reduction plan, prior to the incidents. SP1 was responsible for maltreatment of children.

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 physical abuse and neglect for which SP1 was responsible did not meet the definition of serious as and there was no information that any child sustained a serious injury or an injury that reasonably required the care of a physician. Although the conduct observed by SP2, P1, P2, P3, P4, and P7 happened on multiple occasions with multiple AV's, it was not determined exactly what happened on which date. Rather, this describes a pattern of behavior by SP1 that placed children at risk that is considered a single incident of maltreatment.

Pursuant to Minnesota Statutes, section 260E.35, subdivision 6, paragraph (c) 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 completed an internal review and determined that policies and procedures were adequate but not

followed. This included regarding "developmentally appropriate practices" and supervision. As a result of the incidents, supervisory staff persons were observing transition times to ensure staff persons were following "protocol." Supervisory staff persons were also checking in on staff persons on a "regular basis." P13 also met with P6 and P8 to "confirm" that if any future incidents were to occur, licensing and the child's family was to be "immediately informed." Additionally, staff persons were encouraged to report any incident that jeopardized the health and well-being of a child and who to report to. There were no similar prior incidents regarding supervision of children. However, there was a "pattern of behavior" with SP1. SP1 no longer worked at the facility.

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

On June 30, 2023, the facility was issued a Correction Order for the violations outlined in this.

In addition, it was determined that facility mandated reporters had knowledge of the alleged incident and did not report the incident as required. The license holder ordered to forfeit a fine of $200 for failure to report maltreatment. The Order to Forfeit a Fine is subject to appeal.

Regarding Allegation One:

SP1 and SP2 were not determined as a perpetrator of maltreatment of AV1 because the Department of Human Services found that the incident for which each was responsible met the criteria to be determined a nonmaltreatment mistake. SP1 and SP2 were each notified by the Office of Inspector General that any future incident of possible neglect of an alleged victim for which each was responsible might not be considered a nonmaltreatment mistake.

Regarding Allegation Three:

SP1 was not disqualified from providing direct care services as a result of the maltreatment determination in this report. However, SP1 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 SP1. The determination that SP1 was responsible for maltreatment is subject to appeal.

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.