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: 202308951

Date Issued: January 24, 2024

Name and Address of Facility Investigated:

Little Rebels
255 2nd Ave SW
Wells, MN 56097

Disposition: Maltreatment determined as to neglect of the alleged victim by two staff persons.

License Number and Program Type:

1112016-CCC (Child Care Center)

Investigator(s):

Danielle Morrison
Minnesota Department of Human Services
Office of Inspector General, Licensing Division
PO Box 64242
Saint Paul, Minnesota 55164-0242
danielle.morrison@state.mn.us
651-431-5647

Suspected Maltreatment Reported:

It was reported that a group of toddler and preschool children were on a field trip at a public orchard and while on the fieldtrip, an alleged victim (AV) was without staff person (SP1 and SP2) supervision for at least two minutes.

Date of Incident(s): October 20, 2023

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

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 November 1, 2023; from documentation at the facility; and through six interviews conducted with a facility supervisor (P1), SP1, SP2, and three of the AV's family members (FM1, FM2, and FM3).

The AV was 18 months old and enrolled in the toddler classroom at the time of the incident. Due to his/her age, the AV was not interviewed for this report.

Upon entering the orchard there was an open area to the right that had a concession stand, next to the concession stand was a play area designed for younger children with plastic riding cars and a small swing set, and across from that in the middle of the open area was a shade structure with picnic tables underneath. Just off the open area to the left was a steep giant slide for children to slide down (this was approximately 65 feet from the young play area). There was a steep hill next to the slide or there was a path that was not as steep on the other side of the shade structure that wound down to reach the bottom of the hill.

FM1 stated s/he was at the orchard with FM2, and some other family members on October 20, 2023, when they saw that the AV was there with the facility. FM1 said they "let them be" and went their own way down the hill. When they were coming back up the hill, they saw two staff persons and some of the children on the hill, but the AV was not with them. FM1 and FM2 got in line for concessions and one of the other family members saw the AV playing by him/herself. FM1 said the AV seemed "fine." FM1 and FM2 stayed with the AV and about five to seven minutes later one of the staff persons came up to them "shaking and crying." FM1 stated it was hot that day.

FM2 said that s/he, FM1, and some other family members were at the orchard the day of the incident and they saw the AV was there with the facility. FM2 said the children and staff persons wore t-shirts that identified where they were from. FM2 said s/he gave the AV a hug and a kiss and then FM2 went with FM1 down the hill. When they came up the hill, FM2 saw staff persons in the t-shirts the group was wearing and two children in a wagon, but did not see the AV. FM2 thought maybe the AV was with another staff person. FM2 said s/he and the other family members got in line at the concession stand about two to five minutes after seeing the staff persons on the hill, and that was when another family member saw the AV sitting "calmly" at a table and brought the AV over to FM1 and FM2. Then two staff persons came up the hill looking for the AV. FM2 said it was hot out that day and that there were other groups at the orchard as well.

SP1 provided the following information:

- After lunchtime, SP1 and SP2 took the group of toddler children to the play area and the group of preschool children went down the hill with three other staff persons. SP2 changed some diapers and then SP1 and SP2 went to go down the hill to meet the preschool group. SP1 stated that s/he and SP2 performed a head count before they left the play area.

- SP1 said they had two children in a wagon (not the AV) and four children walking. SP1 had a child's hand in each hand and the AV was holding onto one of those children's hands. SP2 had one child's hand in one hand and the wagon in his/her other hand. SP1 said the hill was "very steep" and it was a "much bigger struggle" to get down with the wagon, so SP1 "paged" P1 to get help. A community person walked by and told SP1 and SP2 there was another way to get down, so SP1 and SP2 went that way. They were a

few steps down the path when another staff person (P2) came to help get the children down the hill. Once they got down and met the preschool group, they counted again and realized the AV was not with them.

- SP1 and SP2 looked for the AV, SP1 ran up the hill and looked over to the bounce house area and did not see the AV, so SP1 looked the other way and saw FM2 holding the AV. SP1 went over to FM1 and FM2 and apologized. FM2 said the AV was sitting at a table. The AV did not seem "distraught." SP2 went back down the hill and SP1 talked to FM1 and FM2 for a little bit and then brought the AV back to the whole group.

- SP1 said it was sunny and hot that day. SP1 said the AV saw FM1 and FM2 earlier and had tried to walk toward them, but once the AV was distracted with the group, s/he seemed "fine" not being with FM1 and FM2.

SP2 provided the following information:

- SP2 said it was warm but not humid and when the whole group arrived at the orchard, they went through different activities that were there. SP2 said the orchard was "really packed." SP2 said FM1 and FM2 were there that same day, and it was a "coincidence" that they were there. SP2 said the AV seemed "confused" that FM1 and FM2 were there as well.

- SP2 brought two children (not the AV) to a portable bathroom to change their diapers, and SP1 stayed with the other children in the younger play area. SP2 said there were six toddler children that s/he and SP1 were responsible for that day.

- SP2 said there was a slide, but they were not going to let the toddler children go on the slide, so they had some children in wagons and some children were walking down the hill next to the slide. It was really "steep," and a community person came over and told SP2 and SP1 there was a less steep way to get to the bottom of the hill.

- SP2 stated they had counted the children at the top of the hill, but still had to go very slowly on the other way down and when they got to the bottom of the hill, they counted the children again and realized the AV was not with them. SP1 and SP2 ran back to the top of the hill and saw the AV with FM1 and FM2. SP2 thought it was "less than five minutes" the AV was not with SP1 and SP2.

P1 provided the following information:

- P1 said the whole group arrived at the orchard, had lunch, and then the preschool children wanted to jump in the bounce houses that were there. That was too much for the toddler children, so SP1 and SP2 took the six toddler children to the play area.

- P1 said FM1 and FM2 were at the orchard that day, but not part of the field trip. The AV saw they were there when s/he was in the play area.

- P1 and two other staff persons then brought the preschool children to the slide. P1 went to the bottom

of the slide and the other two staff persons stayed at the top. SP1 or SP2 used a radio to let P1 know that they were going to change some of the toddler children's diapers. P1 told them to meet them at the bottom of the hill afterwards so they could all go on a hayride.

- SP1 and SP2 had a wagon with some items in it and they used the radio to let P1 know that it was "too hard" to get down the steep hill. P1 sent P2 to assist SP1 and SP2 in bringing the children down. Once they got down to the bottom, SP1 realized the AV was not with the group and s/he ran back to the top to look for the AV and found the AV with FM1 and FM2.

- When SP1 brought the AV back to the whole group, the AV was not crying and did not seem "scared."

- Afterwards, SP1 told P1 s/he had the wagon in one hand and the AV was holding SP1's other hand. They started to fall so that was when SP1 went back up to the top of the hill and used the radio to ask P1 for help. Some community members approached SP1 and SP2 and told them there was another way down to the bottom of the hill that was less steep. That was when SP1 thought the AV went to find FM1 and FM2.

- Initially P1 thought SP1 and SP2 did not come down the hill together, that one of them was changing children's diapers and the other one started to walk down and when they reached the bottom, they realized that neither one had the AV, but after talking with SP2, P1 found out that SP1 and SP2 tried coming down the hill together and went back up to wait until P2 came to help them.

- P1 thought their whole group was going to be alone at the orchard when s/he planned the field trip and did not realize it was during a school break, so it was also open to the public.

FM3 stated that s/he was aware of the incident that happened on the field trip. FM1 and FM2 were at the orchard that day as well and they saw the AV with the facility group. FM1 and FM2 went off to a different area and when they came back, they saw the AV sitting at a table with other children and no facility staff persons. FM2 went over to the AV and asked the community members around the AV if they were facility staff persons, and that was when staff persons came looking for the AV, were "distressed," and saw FM2 holding him/her. FM2 told FM3 it was "maybe a minute or two," but P1 said three minutes. FM3 stated that SP2 was "visibly distressed," was crying, and repeatedly apologizing when FM3 picked up the AV. FM3 had no prior concerns about the facility.

According to www.wunderground.com, on October 20, 2023, around 1 p.m. the temperature at the orchard was 67 degrees Fahrenheit (F°) and the conditions were fair.

The facility's *Risk Reduction Plan* stated that, "Children are always supervised by staff [persons] on field trips or walks."

Facility records showed P1, SP1, and SP2 were trained on the facility's *Risk Reduction Plan* and the reporting of Maltreatment of Minors Act.

Relevant Rule and/or Statute

Minnesota Statutes, section 245A.02, subdivision 18, and Minnesota Rules, part 9503.0045, subpart 1, item A, states that a child must have supervision at all times and that supervision is defined as occurring when 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.

Conclusion:

A. Maltreatment:

Consistent information was provided that on October 20, 2023, a group of children from the facility went on a field trip to an orchard. Sometime after lunch the group of preschoolers and three staff persons went to the bounce houses and to go down the big slide. SP1 and SP2 were responsible for the group of six toddler children, including the AV, and played in the young play area of the orchard. The AV's family members including FM1 and FM2 were coincidentally at the orchard that day as well but were not part of the field trip.

SP2 changed two children's diapers and then s/he and SP1 started to walk down the hill next to the slide. SP1 stated that they counted when they left the young play area and SP2 stated that they counted at the top of the hill which was approximately 65 feet from the young play area. SP1 and SP2 each stated the AV was with them when they started down the hill. SP1 said they had two children in a wagon (not the AV) and four children walking. SP1 had a child's hand in each hand and the AV was holding onto one of those children's hands. SP2 had one child's hand in one hand and the wagon in his/her other hand. The hill was steep and too hard with the wagon, so they used a radio to ask P1 for help. At that time a community member came up to them and told them there was another way down to the bottom of the hill that was not as steep. SP1 and SP2 started to make their way down and P2 joined them to bring the group down. Once they reached the bottom, a headcount was performed, and they noticed that the AV was not with them. SP1 and SP2 went back up the hill and found the AV with FM1 and FM2.

FM1 and FM2 said they saw the AV with his/her group earlier, but the AV stayed with the group. As FM1 and FM2 were walking back to the concession area, they saw the staff persons they saw earlier, but did not see the AV coming down the hill. Another family member saw the AV sitting by the tables nearby with no staff persons, so FM2 stayed with the AV and then after about five minutes from when they saw the staff persons on the hill, two staff persons came up the hill looking for the AV. The AV seemed "fine" and was found by the tables.

The AV was unsupervised for between two to seven minutes which was a violation of Minnesota Statutes, section 245A.02, subdivision 18, and Minnesota Rules, part 9503.0045, subpart 1, item A, prior to being found by FM1 and FM2. Although SP1 and SP2 both stated they counted the children and the AV was with them before going down the hill, and they counted the children once they arrived down the hill and noticed the AV was no longer with them, given the AV's age of 18 months and that no staff person was present to intervene if the AV was injured, or in an emergency, and that the AV was unsupervised in the community for anywhere between two to seven minutes, there was a preponderance of the evidence that there was a failure to supply the AV with necessary care and a failure to protect the AV from conditions or actions that seriously endangered his/her physical or mental health.

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:
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> (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;
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> (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 and SP2 were responsible for the AV's supervision at the time of the incident and were trained on the facility's *Risk Reduction Plan* and the Reporting of Maltreatment of Minors Act. SP1 and SP2 were each 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 SP1 and SP2 were responsible did not meet statutory criteria to be determined as recurring or serious as it was a single incident, and the AV did not sustain any injuries.

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 found their policies and procedures adequate and followed by SP1 and SP2. The facility was looking at the fieldtrip procedures so as to not schedule fieldtrips during school breaks at places like the orchard.

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

SP1 and SP2 were not disqualified from providing direct care services as a result of the maltreatment determination in this report. However, SP1 and SP2 were each 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 disqualification. The determination that SP1 and SP2 were each responsible for maltreatment is subject to appeal.

On January 24, 2024, the facility was issued a Correction Order for the violations outlined 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.