

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: 202308632

Date Issued: March 6, 2024

Name and Address of Facility Investigated:

Brandie's Little Bear Learning Center
1250 Industrial Park Dr.
Eveleth, MN 55734

Disposition: Maltreatment determined as to neglect of three alleged victims by a staff person.

License Number and Program Type:

1093023-CCC (Child Care Center)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that three alleged victims (AV1, AV2, and AV3) were unsupervised by a staff person (SP) and found in a school-age classroom by another staff person.

Date of Incident(s): October 2, 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 2, 2023; from documentation at the facility; and through five interviews conducted with two facility staff persons (P1 and P2), an administrative staff person (P3), the SP, and AV1's family member (FM1). Attempts were made by telephone, email, and mail to contact AV3's family member (FM2), but FM2 did not respond to the requests for an interview. The SP was AV2's family member.

At the time of the incident, AV1 was 21 months old, AV2 was 26 months old, and AV3 was 33 months old. They were enrolled in the Toddler 2 and 3 classrooms.

The toddler bathroom was located at the back of the toddler 2 and 3 classrooms and was shared by both classrooms. The doors to the two toddler classrooms opened onto a hallway. A short distance to the left from the toddler classroom doors, the hallway turned to the left and ran along several classroom doors to the main entrance doors and administrative offices. The door to the school-age classroom was on the right-hand side of the hallway and located a short distance from where the hallway turned to the left. Halfway down the hallway, an adjoining hallway to the right led to the playground door. The main entrance doors to the facility opened into a small vestibule which had a second set of doors to access the parking lot at the front of the facility.

The school-age classroom was a large rectangular room which had several short bookcases placed along the walls holding toys and books. Several tables, chairs, stacked cots, and larger toys such as an easel and shopping cart were placed around the classroom.

P1, P2, P3, the SP, and the facility's documentation provided the following information:

- On October 2, 2023, the SP, P1, and two other staff persons (P4 and P5) worked in the toddler 2 and 3 classrooms. That afternoon, the four staff persons took 14 children from the toddler 2 and 3 classrooms to the playground. P1 stated that a short time later, s/he went into the facility to do the classroom laundry, leaving the SP, P4, and P5 on the playground with the children. At approximately 3:40 p.m., the SP told P4 and P5 that s/he was taking the three children inside to change their diapers and then took AV1, AV2, and AV3 inside to the toddler bathroom. After changing the diapers, the SP and the AVs walked out of the classroom to return to the playground. AV1, AV2, and AV3 ran ahead of the SP down the hallway. The SP had his/her cell phone in his/her pocket because an ongoing family emergency made it important for him/her to be able to take phone calls. As the SP walked down the hallway s/he received a text message on his/her cell phone and checked the text message. The SP stated that s/he watched AV1, AV2, and AV3 walk down the hallway in front of him/her except for a short period of time when s/he looked at his/her cell phone at the text message. The SP arrived to the playground door, at the same time a child and his/her family member entered the facility from the playground and the SP greeted them. The SP believed AV1, AV2, and AV3 went outside to the playground when the child and his/her family member opened the door and entered the facility.
- The SP went outside, where another staff person (P6) stopped to talk to the SP. The SP was "distracted" by P6 and did not count AV1, AV2, or AV3, or look for them when s/he returned to the playground. P2 stated that shortly before 4 p.m., s/he walked out of the facility's kitchen and saw AV1 running in the hallway by him/herself. P2 followed AV1 to the school-age classroom, where s/he also found AV2 and AV3, but no staff persons. The door to the classroom was open when AV1 and P2 entered the classroom. P1 was walking down the hallway after doing the classroom's laundry and saw P2 enter the school-age classroom ahead of him/her. P2 saw P1 in the hallway and told him/her that s/he found AV1, AV2, and AV3 unsupervised in the

school-age classroom. P1 took them outside to rejoin the toddler class and P2 returned to the infant classroom. P1 believed the AVs were unsupervised in the school-age classroom for "a few minutes" and stated that they were playing with toys on the floor when s/he entered the classroom and did not appear to be upset about being unsupervised.

- P2 believed the AVs were unsupervised for approximately one to two minutes. P2 later told P3 about the incident. P3 reviewed the facility's video recording and saw that AV1, AV2, and AV3 were unsupervised in the school-age classroom from 3:46 to 3:50 p.m. The SP stated that three or four minutes after s/he returned outside, P1 came outside with AV1, AV2, and AV3 and told the SP that they were found by P2 inside the facility unsupervised. The SP was unaware that AV1, AV2, and AV3 were not on the playground until P1 brought them outside to the playground and was upset that s/he left them unsupervised. AV1, AV2, and AV3 did not sustain an injury while they were unsupervised.
- The SP and P1 each believed that none of the AVs would be able to open the main door to the facility to exit the building. P2 was uncertain if the AVs would be able to open the main door to the facility. At the end of each day, the various groups of children combined in the school-age classroom to wait for the family members to pick up the children.
- Consistent information was provided that the staff persons were trained to count the children during each transition from one area to another. The three children did not have a history of leaving the group unsupervised. All of the staff persons received training on supervision prior to the incident.

A video camera was located outside the toddler classroom near the classroom door and provided a view of the hallway in front of the toddler classroom (toddler hallway) and the hallway in front of the school-age classroom (school-age hallway). Three videos from the day of the incident did not have sound and there were no time stamps on the videos. However, each video had a timer showing the length of the video. A review of three video recordings from the day of the incidents showed the following:

- Video one (3 minutes 1 second):
 - At the beginning of the video, the hallways were empty and the toddler classroom door was open. At :42, a staff person walked down the school-age hallway, looked into the toddler classroom and then continued to walk down the toddler hallway.
 - At 1:03, the SP and 3 children walked out of the second toddler classroom door, located at the far end of the toddler hallway.
 - From 1:12 to 1:14, the three children ran around the corner ahead of the SP and into the school-age classroom. The SP stopped briefly to look at something on the wall.
 - At 1:19, the SP turned the corner and walked down the school-age hallway. The SP looked at his/her cell phone as s/he walked.
 - At 1:54, a staff person walked down the toddler hallway and entered the toddler classroom.
 - From 2:16 to 2:34, the staff person opened the toddler classroom door and entered the hallway as two children and their family member walked down the school-age hallway and then turned to walk down the toddler hallway.
- Video two (1 minute 25 seconds):

At the beginning of the video, the hallways were empty. At 1:23, AV1 ran out of the school-age classroom and attempted to open the door to the classroom across from the toddler classroom.

- Video three (2 minutes 4 seconds):
 - At :02, AV1 let go of the doorknob of the classroom door, turned, and ran down the toddler hallway and then turned the corner at the far end of the hallway.
 - At :27, AV1 ran back into the toddler hallway from the far end of the hallway. P2 walked around the corner after AV1.
 - At :38, AV1 and P2 entered the school-age classroom.
 - From :42 to :53, P1 turned the corner into the toddler hallway from the far end of the hallway and walked down the hallway as P2 walked out of the school-age classroom and looked down the hallway at P1. P1 entered the school-age classroom.
 - From 1:28 to 1:49, P2 walked out of the school-age classroom and then down the toddler hallway while the three AVs and P1 walked out of the classroom and down the school-age hallway to the hallway leading to the door to the playground.

According to the facility's *Employee Handbook* and the *Risk Reduction Plan*, the staff persons were trained to maintain appropriate staff to child ratios, complete head counts during transitions, and keep all classroom doors closed. The staff persons were to ensure that the children were supervised during transition times and when in the hallways. The staff persons were to perform head counts to ensure all the children were accounted for.

Facility documentation showed that the SP, P1, P2, and P3 each received training on the Reporting of Maltreatment of Minors Act and on the facility's policies prior to the incident.

Relevant Rules and 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:

A. Maltreatment:

On October 2, 2023, the SP took AV1, AV2, and AV3 from the playground to the toddler classroom bathroom. After changing their diapers, the SP followed the three AVs out of the toddler classroom into the hallway. As the three AVs ran ahead of the SP, they turned the corner of the hallway and ran into the school-age classroom. The SP stopped to look at something on the wall and then looked at his/her cell phone as s/he turned the corner and walked down the hallway to the door to the playground. A few minutes later, AV1 ran out of the school-age classroom and down the toddler hallway, where s/he was found by P2, who followed AV1 to the school-age classroom. P2 told P1 that the three AVs were unsupervised in the school-age classroom and P1 took the AVs to the playground and told the SP that the children were found unsupervised in the school-age classroom. The SP had not counted the children when s/he returned to the playground and was unaware that the AVs were not part of the group of children on the playground. P3 later reviewed the video recording and determined that AV1, AV2,

and AV3 were unsupervised for approximately four minutes.

Although AV1, AV2, and AV3 remained in the facility and/or classroom that was designed for use by children, no staff person was aware that the three AVs, who were 21 to 33 months old, were unsupervised which did not allow for staff persons intervention if needed and/or in the event of any emergency. Therefore, there was a preponderance of the evidence that there was a failure to supply the AV1, AV2, and AV3 with necessary care and a failure to protect the AV from conditions or actions that seriously endangered the AVs' physical or mental health when reasonably able to do so.

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

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.

Facility documentation showed that the SP received training on the Reporting of Maltreatment of Minors Act and on the facility's policies prior to the incident. The SP was responsible for the care and supervision of AV1, AV2, and AV3 at the time of the incident.

The SP was responsible for maltreatment of AV1, AV2, and AV3.

C. Recurring and/or Serious Maltreatment:

The Office of Inspector General is required to evaluate whether substantiated maltreatment by an individual meets the statutory criteria to be determined as "recurring or serious." Individuals determined to be responsible for recurring or serious maltreatment are disqualified from providing direct contact services.

Minnesota Statutes, section 245C.02, subdivision 16, states:

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

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

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

It was determined that the substantiated neglect for which the SP was responsible did not meet statutory criteria to be determined as recurring or serious because it was a single incident that impacted three Avs and AV1, AV2, and AV3 did not sustain any injury that required the care of a physician.

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 the facility's policies were adequate, but were not followed by the staff persons.

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

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

“recurring” and will result in the disqualification of the SP. The determination that the SP was responsible for maltreatment is subject to appeal.

On March 6, 2024, the facility was issued a Correction Order for the violation 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.