

**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: 202309493

Date Issued: March 8, 2024

Name and Address of Facility Investigated:

Semcac Head Start Austin
300 16th Street NE
Austin, MN 55912-4596

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

License Number and Program Type:

800141-CCC (Child Care Center)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that a staff person (SP) slapped an alleged victim (AV) on the face.

Date of Incident(s): November 8, 2023

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

"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 for this investigation was obtained remotely, including documentation from the facility and law enforcement records; and through seven interviews conducted with two supervisory staff persons (P1 and P4), three staff persons (P2, P3, and the SP) and the AV's family members (FM1 and FM2).

The AV was four years old at the time of the incident and enrolled in one of the facility's preschool classrooms.

FM1 stated that prior to November 8, 2023, s/he did not have concerns with the SP or the facility. However, after the incident, s/he "realized" there had been some "signs" that s/he had not noticed. For example, when FM1 tried to leave the AV in the classroom with the SP, the AV tried to get FM1 to stay, threw him/herself on the floor, and grabbed FM1's legs. On the day of the incident, FM1 received a phone call from P1. P1 told him/her that the SP slapped the AV. FM1 drove to the facility and arrived at least one hour after the phone call. At that time FM1 did not see any marks on the AV's face. FM1, FM2, and the AV left the facility and met with a law enforcement officer (LEO) and talked about the incident. The AV denied that the SP hit him/her and stated that the SP was "nice."

On November 8, 2023, FM2 received a phone call from FM1, who told him/her about the incident. FM2 left work and drove the facility where P1 met him/her and brought him/her into an office. P1 told FM2 that the AV was "hit" in the bathroom when the SP was helping the AV wash his/her hands. The AV attempted to bite the SP and the SP "slapped" the AV across the face. When FM2 arrived at the facility, the left side of the AV's face was "slightly red," and the AV was "a little fearful," and wanted to go home. The AV did not tell FM2 what had happened.

P1, P2, P3, P4, and the facility's *Accident/Incident Report* provided the following consistent information:

- P2 stated that on November 8, 2023, as the preschool group, including the AV, P2, P3, and the SP was transitioning to breakfast, the group was in the bathroom. P2 was standing by the sinks, P3 was standing by the door, and the SP was by the stalls. The AV was one of the last children to use the toilet and pulled his/her pants up on his/her own. Then the AV and the SP walked to the sink area and were approximately three to four feet away from P2. The SP "grabbed" the AV and the AV was "kicking and screaming" that s/he did not want to wash his/her hands and for the SP to let go of him/her. The SP stood behind the AV at the sinks and tried to get the AV to wash his/her hands. The AV turned his/her head and attempted to bite the SP's right hand. Before the AV could bite the SP, the SP pulled his/her hand away. Then the SP used the top portion of his/her hand and "slapped" the AV's right cheek with the inside of his/her fingers. P2 saw and heard the slap.
- P2 stated that the SP then grabbed the AV's face and said, "I'm so sorry sweetie, [I] shouldn't have done that but how many times have we told you not to bite?" The AV was then "freaking out" more as the SP tried to talk with him/her and was not calming. Then P2 intervened and told the SP that s/he could take the rest of the children to breakfast, and s/he would keep the AV and another child and bring them down when they were done in the bathroom. The SP, P3, and the other children then left the bathroom to go to breakfast.
- P3 said s/he was assisting another child in the bathroom and did not see or hear the SP slap the AV. P3 heard the AV start to cry and looked and saw the AV standing near a wall by the sinks holding his/her head. P3 asked the AV why s/he was crying. The AV did not answer and did not look at P3. Then P3 asked P2 what had happened to the AV and P2 told him/her that the SP slapped the AV on the face. Then

the SP, P3, and the rest of the children left the bathroom to go to breakfast. In the past at an unknown time, P3 had heard the AV tell the SP, "Stay away from me, I don't like you."

- While P2 was with the AV and another child in the bathroom, s/he told the AV that s/he was sorry that the SP had slapped him/her. The AV was still upset and P2 tried calming him/her by letting him/her look at P2's bracelet. P2 looked at the AV's face and saw "four finger marks" that were "big" and "red." After approximately 5 minutes, the AV stopped crying and P2 took the AV and the other child to breakfast. The AV's face was not as red as it had been, but the marks were there for approximately 20-25 minutes.
- The preschool group was the only group at breakfast. The SP had the AV sit next to him/her and then had the AV sit on his/her lap. The SP hugged the AV and held his/her cheek with his/her hand. This made P2 feel uncomfortable because s/he thought the SP "was covering it." P2 asked P3 if s/he saw what had happened in the bathroom and P3 said, "No." Then P2 asked if s/he heard the slap and P3 told him/her "No."
- After breakfast P2, P3, the SP, the AV, and the other children went to their classroom. P2 told the SP that s/he was going to use the restroom. P2 left the room, found P4, and told P4 what had happened in the bathroom.
- P4 stated that P2 talked to him/her. P2 was "visibly shaking and crying," so P4 asked P2 if s/he wanted to leave for the day. P2 told P4 that s/he wanted to leave but s/he did not feel comfortable going back to the classroom to retrieve his/her belongings. P4 then went to the classroom and got P2's things. P4 did not look at any children in the room at that time. P4 told the SP that P2 was leaving for the day and then went to P2 and gave P2 her belongings and P2 left. P4 then called P1 and told him/her about the incident.
- P1 was not at the facility at the time of the incident and received a phone call from P4 at approximately 9:30 a.m. P1 immediately drove to the facility. When P1 arrived, s/he dropped off his/her things and went to the preschool classroom.
- P1 knocked on the classroom door and the SP came to the door. P1 asked the SP to step into the hallway and there P1 asked the SP if s/he had slapped a child. The SP "hesitated, [his/her] shoulders sank down" and the SP said, "Yes." P1 stated that s/he "could see" the SP felt "remorseful."
- P1 told the SP that slapping a child was a violation of the facility's code of conduct and told the SP that s/he would need to go home for the day. P1 stayed with the SP as s/he gathered his/her things and then they walked to an office where the SP gathered more things and then left the facility. P1 then contacted FM1 and told him/her what had happened and FM1 said s/he would come to the facility.
- As P1 waited for FM1 to arrive, FM2 arrived at the facility. P1 explained to FM2 what had happened and then FM1 arrived at the facility. P1 had a staff person bring the AV to them and then FM1, FM2, and the AV left the facility.
- On November 10, 2023, P1 and P2 met with the SP at the facility for approximately 45 minutes. P1, P2, and the SP, sat in desks and discussed how "unfortunate" the incident was and the SP was crying. They also discussed reactions and consequences. P1 could not recall if SP retold P1 his/her account of what had happened during the incident, but the SP never told him/her that the slap was an "accident." The SP

told P1 and P4 that the "slap" was reactive." The SP told P1 that the AV bit him/her and s/he "slapped" him/her. P1 stated that the SP had been coached in the past about using "harsh" words when talking with children. P2 stated that the SP was patient but was "loud spoken." P3 stated that "sometimes" the SP talked "loud" to the AV.

The SP provided the following information:

- On November 8, 2023, FM1 brought the AV to the facility later than usual. After FM1 left, at approximately 8:45 a.m., the group, including, P2, P3, the SP, and the AV, left the classroom and stopped in the bathroom.
- The AV was in front of a toilet when the SP told him it was time to move on and wash his/her hands. The AV told the SP that s/he "had to go," and the SP told him/her that s/he had been there for "five minutes," and it was time to leave the bathroom and go to breakfast.
- The SP walked over to the AV and pulled up his/her undergarments and pants. The AV was "mad" and started to cry because s/he was not able to "finish going potty." The SP told the AV, "Come on, let's get your hands washed." The SP walked with the AV to the sink and stood behind him/her at the sink. The SP leaned over the AV and assisted him/her by doing "hand over hand" handwashing. The AV "was fighting" the SP with the handwashing and attempted to bite the SP's right hand. The SP said s/he pulled his/her right hand back and the backside of the SP's hand, between the thumb and pointer finger, "caught" the AV's right cheek between his/her nose and ear.
- The AV had already been crying so there "was no real difference" in the AV's behavior. Then the SP hugged the AV and told him/her that s/he was sorry and that s/he did not "mean to do that." The AV hugged the SP back and said, "It's ok." After that the SP and the AV were "fine." The SP did not see a mark on the AV's face.
- The SP said that when his/her hand made contact with the AV's face there "might have been a connect sound," but "it was not an open-hand slap."
- P2 was standing closest to the SP and the AV and was getting a paper towel for another child. P2 "probably saw" the SP's hand go back and "might have heard a noise." P3 did not know that anything had happened in the bathroom.
- Then the group transitioned to breakfast. The SP could not recall if the AV went with the SP, P2, P3, and the other children or stayed with P2. The SP believed that if the AV had a mark on his/her face, staff persons at breakfast would have asked what had happened and no one did.
- After breakfast the group, including P2, P3, the SP, and the AV transitioned back to the classroom. Shortly after, P2 left the classroom and not long after, P4 came to the classroom and told the SP that s/he was sending P2 home. P4 gathered P2's things and left the room. The SP thought that P2 must have been ill.
- Before lunch, P1 knocked on the classroom door and asked the SP to come out to the hallway. P1 asked the SP if s/he slapped a child. SP thought, "Oh shoot, [P2] said something." The SP said, "Yes," and told P1 that his/her hand had went up to the AV's face. The SP thought that at that time, s/he told P1 that s/he did not slap the AV. P1 told the SP that s/he was sending him/her home. The SP was "hoping" that

P1 would hear his/her "side of the story."

- On November 9, 2023, the LEO called and spoke with the SP about the incident. The SP stated the LEO told him/her that "after investigating," s/he thought that the SP's action was a "knee-jerk" reaction.
- On November 10, 2023, the SP met with P1. They "talked," and the SP told P1 what the LEO had told him/her and that this situation was "hard." The SP also told P1 there was no "redemption" for him/her, that there was no "counseling" for a week, no "you're off work without pay for a week," or you "take seminars." P1 told the SP that s/he felt bad that s/he let his/her "mental health get to this point." SP1 stated that P1 told him/her that they "knew" s/he was a "good person."
- The SP stated she "reacted," and felt like s/he was "robbed" of being able to tell what had happened.

Law enforcement documentation stated that On November 8, 2023, the LEO met with FM1 and FM2. who told the LEO that they had learned that the SP had hit the AV. The LEO went to the facility and talked with P1 who told the LEO about the incident and gave him/her written statements from P3 and P4. On November 9, 2023, the LEO returned to the facility and talked with P2. When the LEO left the facility, s/he called the SP. The SP told the LEO that s/he "slapped [the AV] on the mouth to prevent [him/her] from biting." The SP told the LEO that the "slap" was not a "hard slap" and was an "immediate response." After s/he did that, the SP thought to his/herself, "I can't believe I just did that." The SP "felt horrible" and "did not mean to do it." After speaking with everyone, the LEO determined that "there was no malicious intent behind the incident and appeared to be an instinctual immediate reaction rather than a punishment or malicious correction." No further action was taken.

The facility's *Behavior and Guidance Support* policy provided the following information:

- Staff persons emphasized nurturing and responsive practices, interactions, and environments that fostered trust and emotional security.
- Staff persons used unwanted behavior as a learning opportunity to encourage self-control, self-direction, self-esteem, and cooperation.
- When a child exhibited persistent unsafe behavior, such as biting, staff persons could redirect the child to another activity, gently hold the child, model self-regulation techniques, or notify the site manager.
- Staff persons were prohibited from using corporal punishment discipline that included rough handling, shoving, hair pulling, ear pulling, shaking, and slapping.

Facility documentation showed that P1-P4 and the SP had received training on the facility's *Behavior and Guidance Support* policy, and the reporting of Maltreatment of Minors Act.

Relevant Rules and/or Statutes:

Minnesota Rules, part 9503.0055, subpart 3, item A, state that the license holder must have and enforce a policy that prohibits the subjection of a child to corporal punishment. Corporal punishment includes, but is not limited to, rough handling, shoving, hair pulling, ear pulling, shaking, slapping, kicking, biting, pinching, hitting, and spanking.

Conclusion:

A. Maltreatment:

Consistent information was provided that on November 8, 2023, the AV went into the bathroom with the SP, P2, P3, and other preschool children. The AV did not want to wash his/her hands for breakfast, was upset, and the SP assisted the AV with handwashing. While the SP assisted the AV with handwashing, the AV attempted to bite the SP's right hand and the SP slapped the AV's face.

P2, who was standing near the AV and the SP, said s/he saw the SP slap the AV with the inside portions of his/her fingers and heard the slap. P3 did not see the incident but saw the AV holding his/her head and crying.

The SP provided different accounts of the incident. Shortly after the incident, when P1 asked the SP if the SP slapped a child, P1 said the SP "hesitated, [his/her] shoulders sank down" and the SP said, "Yes." The law enforcement documentation stated that the day after the incident, the SP told the LEO that s/he "slapped [the AV] on the mouth to prevent [him/her] from biting." The SP told the LEO that the "slap" was not a "hard slap." The SP told this investigator that the AV "was fighting" the SP with the handwashing and attempted to bite the SP's right hand. The SP said s/he pulled his/her right hand back and the backside of the SP's hand, between the thumb and pointer finger, "caught" the AV's right cheek between his/her nose and ear.

The SP's action of slapping the AV was inconsistent with the standards of a professional caregiver in a facility licensed by the Minnesota Department of Human Services; a violation of the facility's *Behavior and Guidance Support* policy; and violations of Minnesota Rules, part 9503.0055, subpart 3, item A.

Given that the SP provided different accounts of the incident to P1, the LEO, and this investigator; that the SP initially told P1 and the LEO that s/she had "slapped" the AV; that P2 said saw and heard the slap; that P3 saw the AV crying with his/her hand on his/her cheek; and that there were finger marks on the AV's face that lasted up to 25 minutes, there was a preponderance of the evidence that the SP's actions were not accidental and caused injury and/or represented a substantial risk of injury to the AV.

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.

The SP was trained on the facility's *Behavior and Guidance Support* and the Reporting of Maltreatment of Minor's Act. The SP was responsible for maltreatment of AV1.

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 for which the SP was responsible did not meet statutory criteria to be determined as recurring or serious. It was a single incident and although the AV initially had a red mark, the mark disappeared within one hour so was transitory in nature and not tissue damage.

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 their policies were adequate but not followed by the SP. The SP no longer worked at the facility.

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 8, 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.