

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: 202308848

Date Issued: July 5, 2024

Name and Address of Facility Investigated:

Semcac Head Start Austin
300 16th St. NE
Austin, MN 55912

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

License Number and Program Type:

800141-CCC (Child Care Center)

Investigator(s):

Thomas Nixon
Minnesota Department of Human Services
Office of Inspector General, Licensing Division
PO Box 64242
Saint Paul, Minnesota 55164-0242
thomas.c.nixon@state.mn.us
651-431-2155

Suspected Maltreatment Reported:

It was reported that an alleged victim (AV) was slapped in the mouth by a staff person (SP).

Date of Incident(s): October 16, 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 was obtained during a site visit conducted on November 11, 2023; from documentation at the facility; and through six interviews conducted with one supervisory staff person (P1), three staff persons (P2, P3, and the SP), and two family members (FM1 and FM2).

The AV was two years old at the time of the incident. The AV enjoyed movies, playing with toys and sand, and cooking. The AV started to attend the facility in August of 2023.

Due to the AV's age s/he was not interviewed.

P2 provided the following information:

- On October 16, 2023, around 2:20 p.m., P2, P3, and the SP brought five children to the bathroom after nap time. P2 and P3 monitored four children while the SP sat in a chair and changed the AV's diaper. P2 was standing approximately two feet away from the SP and the AV and was faced towards them, and P3 was standing behind the SP. The AV was between the SP's legs and faced towards the sinks.
- During the diaper change, the AV's motions appeared as though s/he planned to bite the SP. The SP took his/her right hand and "popped" the AV in the mouth. P2 "clearly heard...the pop" and it sounded "hard." P2 said on a scale of one to ten, the force of the "pop" was a seven. The AV started crying immediately.
- The SP realized that P2 saw what happened and displayed a look on his/her face P2 interpreted as, "Shit, [P2] saw it... how people look like when they are like, 'I am busted.'" The SP said, "It wasn't that hard," and finished changing the AV's diaper while the AV continued to cry. The SP said to the AV, "You are okay, let's go wash your hands so we can go to snack," then walked the AV over to the sink, and washed their hands. The SP saw there was blood on the AV's lip and said, "Oh, you're bleeding, here, let me wipe it off. . . you are okay, we don't try to bite." The SP then used a wet paper towel to dab the AV's right lower lip.
- P2 did not know whether P3 was aware of the incident. Although P3's body was facing the SP and the AV when the incident occurred, and P3 would have been able to hear the impact noise and the AV crying, P3 may have been looking away from the SP and the AV when the incident occurred, and P3 did not appear to respond to the incident.
- The group left the bathroom and the AV continued to cry as they walked to the cafeteria for snack. The AV's initial "hurt cry" turned into a "whiny cry, more upset cry" on the walk to snack, and in the cafeteria. The AV sat at a table with the SP and P3 while P2 sat at a table with some of the other children. P2 did not notice anything unusual with the AV during snack. P2 did not get a good look at the AV's face and lip mark the rest of the day and did not take a photo of the mark. Around 2:30 to 2:35 p.m. the AV finished snack and was picked up by FM2 to go home. P2 did not talk with FM2 at pick up.
- P2 did not talk with the SP or P3 about what happened to the AV in the bathroom.
- On October 17, 2023, the AV's lower lip was "a little discolored" with a "tooth mark" that was "a little

darker than [the AV's] lip color." P2 was not in the AV's classroom that day and had limited interaction with him/her. The SP was "a little bit over the top nice" towards P2 that day which P2 interpreted to mean, "[The SP] knew [s/he] did something wrong and was afraid of what was going to happen." Later that day, P2 called P1 to report what happened in the bathroom between the SP and the AV the day before.

P3 provided the following information:

- On an unknown date, around 2:05 to 2:10 p.m., P3, P2 and the SP brought several children into the bathroom. In the bathroom, P3 and P2 helped some children while the SP did diaper changes. P3 was focused on the children s/he was with, who were attempting to run out the door of the bathroom, and "wasn't necessarily paying attention" to what went on around him/her beyond that. P3 did not see or hear the SP slap the AV.
- Upon exiting the bathroom, P3 saw that the AV was "having a fit" and the SP carried him/her. The AV screamed, kicked, and appeared to not want to leave the bathroom. P3 did not ask the SP about the AV's behavior as it was "a usual thing for [the AV]" who had difficulty with transitions. The group got to the cafeteria around 2:15 p.m. and P3 sat with the AV and the SP at a table. The AV appeared "upset" until s/he ate and drank, then s/he calmed. P3 did not see any bleeding from the AV. The AV had a "good" rest of the day and appeared "happy."

P1 provided the following information:

- On October 17, 2023, around 4 to 4:30 p.m., P1 received a call from P2 who said, "I don't like doing this, but I have to tell you I saw someone hit a child yesterday." P2 proceeded to provide information to P1 about the incident that was consistent with the information s/he provided in his/her interview with the DHS investigator.
- P2 and the SP "didn't have the best relationship," and in the past the SP thought P2 acted disrespectfully towards the SP.
- On October 18, 2023, P1 met with the SP. The SP spontaneously asked if the meeting was about what happened in the bathroom. The SP said the AV had a "hard time" throughout the day of the incident. While the SP and the AV were in the bathroom, the AV acted like s/he wanted to bite the SP. The SP said the AV did not actually bite him/her, but the SP "reacted," and, "I hit [the AV] in the mouth. It wasn't a hard hit." The SP said the AV was "fine," and when they went to wash his/her hands the SP saw the AV was bleeding. The SP said the AV might have injured him/herself when biting the SP. P1 asked the SP to clarify, as the SP said the AV did not bite him/her. The SP then said the AV did not bite him/her and that s/he did not know where the blood came from. The SP said s/he was related to the AV, which was the first time P1 was made aware of this. P1 said there was no policy that a family member could not work with a child.
- The AV's lip had "a little bit different coloring," but P1 did not see "a cut or anything."

FM1 and FM2 provided the following information:

- On October 16, 2023, FM2 picked up the AV from the facility, the AV was “fine” and FM2 did not see any marks on the AV. FM1 did not notice anything unusual about the AV that evening. FM1 said, “If they hadn’t said anything I would not have known.” On October 19, 2023, FM1 got a call from P1 who said on October 16, 2023, the AV “pounded” his/her head into a staff person’s chest and intended to bite a “helper,” then the AV was “hit in the mouth” by a staff person.
- The SP was a family member of the AV, FM1 and FM2. The SP was very good with children, would not have done anything intentional to hurt the AV, and the SP said the situation was an “accident.” While FM1 liked the idea of a family member being in the classroom with the AV, since the AV knew the SP as a family member s/he was likely to “act out more” at the facility. The AV played “rough” at home and wrestled with his/her siblings. The AV “puts [his/her] mouth on you, but not to bite.” The AV was not known to do this to strangers, only to family members.

The SP provided the following information:

- The SP was a family member of the AV, FM1, and FM2. When the AV was upset, s/he “[threw] a tantrum” and cried until a staff person picked him/her up. FM1 previously told the SP, “If [the AV] gets like this spank [his/her] butt.” The SP told management at the facility and other staff persons about the family connection to the AV.
- On October 16, 2023, the AV was “definitely was off,” was “more hesitant,” and cried “a few times.” In the classroom, at an unknown time, and for an unknown reason, the AV “head butted” the SP in the chest. The SP said it was “hard enough to. . . off kilter my balance completely.”
- Later that day, the SP was in the bathroom with five to six children, P2 and P3. The SP sat on a chair and the AV stood between his/her legs. The AV was turned to the side and facing P2. P2 and P3 were assisting the other children nearby.
- The AV did not want to go to the bathroom and was “crying and kicking.” The AV “aggressively... slammed [his/her] face” into the SP, trying to bite either the SP’s right arm or leg (the SP could not recall which). The SP “felt [the AV’s] teeth” and there was a “wet spot” on the SP’s clothes from the AV’s mouth. The AV then crouched down between the SP’s legs.
- The SP picked up the AV and stood him/her up again. The SP then “tapped” the AV on the mouth with two fingers of his/her open hand and told the AV, “Don’t bite.” The AV seemed “scared” and “shock[ed]” and appeared to “surprise cry.”
- The SP finished with the AV’s diaper change and walked him/her over to the sink and washed his/her hands. The SP crouched down, gave the AV a hug, said, “It’s not nice to bite our friends,” and the AV stopped crying. The SP saw that the AV had “a little bit of blood on [his/her] lip.” The blood “wasn’t gushing,” and came from a cut on the right side of the mouth inside the “crease of the lip.” The cut was “not even a toddler tooth width.” The SP took a napkin and wiped the AV’s lip. The napkin had a “teeny tiny drop of blood” on it. The SP was uncertain if the cut on the AV’s lip came from when the AV “slammed” his/her face on the SP in the attempt to bite the SP, or when the SP “tapped” the AV on the

mouth. The SP said, "I don't feel like I tapped [the AV] that hard." The SP denied having any conversation in the bathroom about what happened with P2 and P3.

- The group left the bathroom and walked down a hallway to the cafeteria. The AV appeared "fine" and held the SP's hand on the walk. The SP did not recall if s/he carried the AV to the cafeteria and denied the AV cried on the way. The SP sat with the AV in the cafeteria and saw that the AV was able to eat snack without issue. The AV did not appear to be in any pain or discomfort and had a "normal" rest of the day. The SP was not present when FM2 picked up the AV, so s/he was not able to communicate what happened earlier in the day. The SP did not document the incident in the bathroom with the AV or the injury.
- On October 18, 2023, the SP met with the facility management and was asked questions about what happened with the AV, and s/he gave the above information. The facility management appeared "surprised" that the SP and AV were related as though they were not previously aware.
- The SP had no intention to hurt the AV and said of his/her actions, "It wasn't the best judgement." The SP had a "hard time maintaining the professional line being that it was my family." The SP said the situation could have been avoided if there was a policy that staff persons were not able to work with family.

According to the facility's *DHS Policies and Procedure for Team Members*, under Behavior Guidance, "All staff are prohibited from using discipline such as: Subjecting a child to corporal punishment, this includes rough handling, shoving, hair pulling, ear pulling, shaking, slapping, spanking, etc." Staff persons were to "use each unwanted behavior as a learning opportunity to teach the missing skill for continued growth in safety, connection, and problem-solving. Staff uses Conscious Discipline, which encourages self-control, self-direction, self-esteem, and cooperation."

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 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.

Conclusion:

A. Maltreatment:

On October 16, 2023, around 2 p.m. the SP was in the bathroom with the AV, P2, P3, and other children. The SP sat in a chair and was diapering the AV who stood between the SP's legs. P2 and the SP provided consistent information that the AV appeared to try to bite the SP, then the SP used his/her hand to hit the AV's face, which caused the AV to cry. P2 said the hit caused a "pop" that sounded "hard." The SP brought the AV to the sink to wash his/her hands, saw blood coming from the AV's lip, and wiped the blood off. Although P2 and P1 each said

the AV's lip was discolored on October 17, 2023, FM1 and FM2 said they did not notice any mark and the AV was "fine" when they picked up the AV from the facility on October 16, 2023.

Hitting the AV on the face was inconsistent with the standards of a professional caregiver in a facility licensed by the Department of Human Services; was a violation of the facility's policies; and was a violation of Minnesota Rules, part 9503.0055, subpart 3, item A. It was unknown whether the AV's injury was caused by his/her attempt to bite the SP or by the impact from the SP's hand. However, the SP's actions of hitting the two year old AV on the face hard enough to produce a "pop" that sounded "hard," and which caused the AV to cry, represented a substantial risk of physical or mental injury to the AV. Therefore, there was a preponderance of the evidence that the SP inflicted threatened injury on the AV other than by accidental means.

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 Reporting of Maltreatment of Minors Act and the facility's Behavior Guidance policy. The SP was responsible for maltreatment of the AV.

C. Recurring and/or Serious Maltreatment:

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

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

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

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

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

It was determined that the substantiated physical abuse for which the SP was responsible did not meet statutory criteria to be determined as recurring or serious because it was not determined whether this single incident of physical abuse caused injury to the AV.

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 and were 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.

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.