

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: 202404498

Date Issued: July 11, 2024

Name and Address of Facility Investigated:

LSS Early Learning Center Frogtown-Rondo
709 University Avenue
Saint Paul, MN 55104

Disposition: A nonmaltreatment mistake to an alleged victim by a staff person was not maltreatment.

License Number and Program Type:

1109590-CCC (Child Care Center)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that an alleged victim (AV) left through an unlatched playground gate without the knowledge or supervision of a staff person. The AV walked onto or up to a nearby street where a community person stopped their vehicle and returned the AV to the facility, unharmed. The AV was unsupervised for about one minute.

Date of Incident(s): May 23, 2024

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 June 18, 2024; from documentation at the facility; and through interviews conducted with the AV's family member (FM), a community person (CP1), facility staff persons (SP1, SP2, and SP3), and a supervisory staff person (P). Consistent information was provided that the AV was "nonverbal" and/or "underdeveloped" and would not be able to provide information for this investigation. The AV was not interviewed.

The AV was three years old and enrolled in the facility's young preschool classroom.

A Saint Paul Public Schools *Evaluation Report* included the following:

- On April 24, 2024, the AV was diagnosed with Developmental Delay. This included the areas of cognitive, gross/fine motor, communication, social-emotional, and adaptive areas of development.
- Information from the AV's previous childcare provider stated, "[The AV] wanders around outside. [S/he] sometimes follows a similar path. [S/he] will put sand in [his/her] mouth if given an opportunity to do so. [S/he] doesn't interact with the other kids, and sometimes doesn't even notice that they are around ... [S/he] doesn't follow verbal directions, they always need to go and get [him/her] and take [his/her] hand away from something or guide [him/her] towards something else ... [S/he] likes to walk around by [him/herself]. Safety is a concern because [s/he] frequently puts things in [his/her] mouth ... When [s/he] is done with an activity or not interested, [s/he] will walk away."
- "[The AV's] adaptive delay impacts [his/her] ability to remain safe in typical play environments."
- "[The AV] does not respond to [his/her] own name."

The facility did not have or develop an individual child care program plan (ICCPP) for the AV, which was required under Minnesota Statutes 9503.0065, therefore a licensing violation was determined.

The facility was located on University Avenue in Saint Paul, MN about one and a half blocks (1200 feet) from the intersection with Dale Street. University Avenue was two lanes of 30 mile per hour (mph) traffic in both directions (east and west) with a light rail track (green line-passenger urban rail transit) down the center separating the east and west lanes with concrete barriers. The light rail train did not normally exceed 35 mph. A light rail station was nearby, a fire station was next door, and several restaurants and businesses lined either side of the street. In addition, city buses traveled University Avenue and there were several bus stops in the area. There were mature trees, streetlights, garbage cans, and other objects set along sidewalks running parallel to the street on either side. Single family housing was in the blocks behind the facility.

At the time of the site visit, this investigator toured the playground. The playground was located on the east side of the building and could be accessed through a side door on the building or a gate facing University Avenue. The playground was bordered by the building, an alley, and a parking lot. The facility had two types of fencing, wooden and chain link. The wooden fence was along the alley and the chain link was along the parking lot. The chain link fence was wrapped in a dark green tarp-like material, which limited visibility out and in. The bulk of the playground was contained in a square; this included play structures, sandboxes, picnic tables, and benches, and a tire swing. There was then a smaller concrete pad off the south side of the playground running along the building toward University Avenue. This area was narrower than the playground. The same tarp-like material covered the

fencing along the concrete pad. The gate was at the farthest point on the concrete pad from the rest of the playground. The gate and fencing closest to the building did not have the tarp. The gate had a magnetized entry via a keycard/badge. When the gate contacted the magnet, it was supposed to connect (lock) and remain connected until the next keycard or badged entry. If someone was standing on the concrete pad, they might see a section of the playground but not the entirety and similarly, if someone was standing in the playground, they might not be able to see the concrete pad or the gate. The gate faced University Avenue and was approximately 50 feet from the road. A camera was located outside the facility that showed the playground gate, portions of the parking lot, and University Avenue. The playground was not visible via the camera.

The FM provided the following information:

- When the AV applied to enroll at the facility, in early May 2024, the FM met with the P for over an hour talking about the AV's needs. The FM told the P more than once that the AV was "a wanderer." "[The AV] doesn't talk and is underdeveloped. [The AV] will wander, pull on the gates, and look for an opening. [The AV] will eat the trees and go into the mud puddles." The FM believed that if the facility was not able to handle the AV's needs, then they should have rejected the AV's application to enroll at that time. On May 7, 2024, the facility accepted the AV's application and enrolled him/her in the young preschool classroom.
- On May 23, 2024, the FM received a call from the P. The P said that the AV pushed open the playground gate, which was "not locked" and wandered out. The AV was unharmed. The FM "wasn't satisfied" with the facility's supervision, which allowed the incident to occur, and with the amount of information provided about what happened. According to the FM, the P's call notifying of the incident lasted about three minutes. The FM had a lot of questions about what happened. "[The AV] made it onto University (Avenue) ... We are talking University Avenue," which had "heavy traffic" and the light rail. The AV was brought back to the building by a community person. "This is serious. This could have been an Amber Alert, or [s/he] could be dead." [Note: An Amber Alert is a child abduction emergency alert system.]
- The FM wondered where the staff were on the playground and why the gate was open. When the P called the FM about the incident, the P implied that it was "[the AV's] fault." The FM said that if the same thing happened to him/her, whereby the AV wandered onto University Avenue while under the FM's care, child protective services would be involved. The FM did not believe the facility was taking responsibility. "You can't blame this three-year-old child. You were not watching [him/her]."
- The FM also had concerns about the location of the gate. It was on a concrete pad within the enclosed playground; however, it was around a corner from the rest of the playground. The FM did not believe children should be on the concrete pad unless the facility planned to station a staff person right there. When the FM inquired about this with the P, the P said that the concrete pad was part of the playground and accessible to children using the playground.

The facility's camera footage provided the following information:

- A small bus was parked in the parking lot as well as other vehicles.
- On May 23, 2024, at 11:25:00 a.m., SP1 approached the gate from the parking lot. SP1 held a keycard or badge to the gate and the gate opened. SP1 walked through the gate and pulled the gate shut behind him/her glancing briefly back to look at the gate. SP1 then walked off camera into the playground. After

SP1 shut the gate, the gate moved slightly back and forth but did not appear to reopen in any obvious way. However, it also it did not clearly show whether the gate was locked/re-magnetized. There was no one else visible at that time.

- At 11:27:02 a.m., the AV walked into camera view, up to the gate. There was no one with the AV. The AV put both of his/her hands on the gate. The gate immediately moved in response to the AV's contact. The AV continued pushing and the gate opened several feet and remained as such; the gate did not spring shut and/or the AV did not have to hold it open.
- The AV walked through the gate and toward the parking lot. The AV stopped and looked back at the gate; no one else was visible or following the AV. The AV then turned and walked toward University Avenue. As s/he approached, two vehicles were heading in his/her direction: a large red truck was in the far-left lane and a white sport utility vehicle (SUV) was in the right lane, closest to the AV. The AV took about two to three steps onto University Avenue in front of the white SUV and just as the truck was passing in the other lane. The white SUV slowed about two car-lengths from the AV and came to a stop. The passenger door opened, and a community person (CP2) stepped out. The AV immediately walked toward CP2. CP2 pointed toward the parking lot and took hold of the AV's hand. CP2 and the AV walked toward the open gate.
- At 11:28:08 a.m., SP3 walked through the gate and up to CP2 and the AV, who were about halfway to the facility from the street. SP3 took the AV's hand and led him/her back to the gate. CP2 got back in the SUV, and they drove away. SP1 was also at the gate now with one other child, both watching what was happening.
- At 11:28:24 a.m., the AV was back inside the playground and SP1 and SP2 were holding the gate closed. SP1 and SP2 appeared to struggle to either lock the gate or get it opened again. SP3 pushed more than once on the gate while SP1 pushed a button on the side of the building. At various points the gate popped open and at other points it appeared to be secured.
- SP1 and SP3 then left the camera view while two children remained next to the gate. One child repeatedly pushed on the gate and the gate did not open.
- At 11:29:36 a.m., SP1 and SP3 returned and led the children away from the gate.

CP1 provided the following information:

- On the date of the incident, CP1 was driving west on University Avenue in the right lane, closest to the sidewalk, and on the same side of the light rail as the facility. CP2 was in the front passenger seat.
- CP1 saw the AV walking toward the street. CP1 did not see any adults with the AV. CP1 slowed his/her vehicle and stopped next to the AV while turning on his/her vehicle hazard lights. "I was pretty worried that [s/he] was going to walk into my path of driving, which I had already slowed to a stop, but I was worried [s/he] was going to cross my vehicle into the far-left lane." "I was worried for the traffic on the street and the foot traffic because you never know who is going to snatch a kid like that."
- CP2 got out of the vehicle and took the AV's hand "right as [s/he] was about to, looked like [s/he] was

about to, step off the side of the road” into the next lane of traffic. CP2 walked with the AV toward a gate on the side of the building when a staff person came out of the gate and walked toward them. CP2 told CP1 that the staff person appeared “fluttered” and told CP2 that the gate was broken, which was how the AV was able to leave.

- CP1 said that traffic at that time of day was “mild” and that maybe one or two vehicles had driven past during that timeframe.

SP1, SP2, and SP3 provided the following information:

- On May 23, 2024, SP1, SP2, and SP3 were on the playground with ten children. SP1 and SP2 brought eight children to the playground, including the AV, and SP3 brought two children.
- SP1-SP3 each said that at the time of the incident, they were allowed to use the playground gate for personal reasons, such as to access the parking lot or for break times, etc. Children only used the gate to get on and off the bus at the beginning and end of each day.
- At the time of the incident, they had been on the playground for about 20 minutes.
- SP1 said that s/he approached the gate from the parking lot and opened it using his/her keycard or badge. SP1 stepped through and pulled the gate closed. “I felt it shut behind me ... It didn’t bounce back open ... It felt normal to me.” SP1 continued onto the playground and could not see the gate at that time.
- SP2 was sitting on a bench along the building facing the playground. The gate was to his/her right a distance away. “It was in my peripheral (vision).” SP2 saw a child about to fall asleep on the tire swing. SP2 helped this child off the swing and then held him/her on SP2’s lap on the bench. SP2 was not looking at the gate.
- SP3 was not in “eye view” of the gate. “I was playing with my students out of view of the gate.”
- SP3 then walked across the playground, which brought the gate into view. SP3 saw the gate open and immediately went over to it. SP3 then saw CP2 walking with the AV toward the building. The AV was “completely calm” and “wasn’t crying or upset.” SP3 thanked CP2 and brought the AV back through the gate.
- SP1 heard “panicking” and ran to the gate and saw the AV outside the playground with CP2. SP1 said, “[The AV] made it to the street, which is very, very scary.”
- SP2 said, “[The AV] is trusting ... [S/he] would go with anyone. [S/he] has no stranger danger. If [s/he] sees a door open, [s/he] is going to run but [s/he] is not going to have a clue on what to do. I don’t know if [s/he’d] go up to anyone unless they approached [him/her], which is very scary.” “It could have ended badly.”
- SP3 said that the magnet on the gate was “not ideal.” “It didn’t have a spring system. If you let it close on its own, it’s not going to swing shut. I know that because I’ve been here. It has to be intentionally closed. But, we hadn’t had any incidents that brought it to light.”

- SP1 said that the gate was bent, which sometimes prevented it from making direct contact with the magnet. One time when SP1 was on the playground, the P came through the gate to talk briefly with staff and then left through the same gate. About five minutes later, an unidentified child pushed the gate open. A staff person was right there to immediately pull it closed. SP1 did not know if the gate malfunctioned in that instance or if the P failed to close it correctly. SP1 believed that SP3 had something similar happen once. SP1 was not aware of any other similar instances.
- SP2 said that one time s/he went to his/her vehicle through the playground gate. There were no children on the playground at the time. When SP2 returned, s/he found the gate "didn't latch" behind him/her and was open. This incident made SP2 aware that it took a few seconds for the gate to "click," which meant it was locked. "I didn't know that until after the fact." At the time, SP2 believed ice or snow might have played a role in the magnet/lock not connecting. SP2 was not aware of any other similar instances.
- SP2 said that "usually" when children were present, there were four staff on the playground and sometimes, five. SP2's classroom combined with the AV's classroom on the playground. "Normally on any given day" a staff would be sitting on the concrete pad and someone else might be sitting at the picnic tables; however, this was not typically discussed or planned but rather staff moved around the playground as needed.
- SP1 said that staff "rotate" on the playground and "usually cover everything at once." "When kids are over there (by the gate), we will be in the area." Staff "kept track of [the children] generally" on the playground. There were no specific instructions that SP1 could recall from his/her training. "I'm always keeping count." The facility had small group sizes and so it was "easy to keep track of" the children.
- SP3 said, "Typically, there are a lot of staff outside at a time ... Teachers are engaging over there (by the gate). We don't have specific protocol about someone being at the gate."

The P provided the following information:

- The AV was "nonverbal ... just turned three ... kind of spacey and won't answer to [his/her] name. [S/he's] a wanderer and a dreamer." The AV was "very new" to the facility. They had not developed any specific plans for the AV beyond what was already in place for all children. The facility served children, who needed additional support due to past stress and trauma, and/or developmental needs. Staff received additional training to work with the specific clientele. The facility maintained a staff to child ratio for all age groups of 1:4.
- The FM told the P that the AV was "a wanderer." The facility did not provide additional instruction to staff about this. "Because we have locked gates and badge entry ... We count on our equipment."
- At the time of the incident, "It seemed the gate failed ... We determined this was an equipment failure." Once the P was notified of what happened, s/he tried to reproduce the same problem with the gate but was unable. The gate remained locked and/or opened as intended. "Within two hours" of the incident, there was a facility maintenance person at the facility inspecting the gate. The gate was replaced a few weeks later and while awaiting the replacement, the P remained stationed at the gate anytime there were children present.
- One time prior to May 23, 2024, "the latch came loose" on the gate but there was a staff person right

there who caught it. The P was not aware of other instances when the gate failed to lock.

- Children liked to ride bikes on the concrete pad and use chalk. Staff were supposed to remain “within line of sight of all children” when on the playground.
- The P had no prior concerns with SP1’s, SP2’s, and/or SP3’s conduct.

The facility’s *Risk Reduction Plan* stated, “[The facility] is located in highly urban area ... on University Avenue, which consistently has busy traffic ... busy street with cars, bus, and light rail traffic.” Exterior doors and the playground gate were keyed doors with alarm systems. “Outdoor play is always staff supervised ... by sight and sound.”

Facility documentation stated that SP1, SP2, SP3, and the P received training on the facility’s *Risk Reduction Plan* and the Reporting of Maltreatment of Minors Act.

Relevant Minnesota Statutes and Rules:

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:

On May 23, 2024, the AV left the playground through an unlocked gate without a staff person’s knowledge or supervision, which was a violation of Minnesota Statutes, section 245A.02, subdivision 18, and Minnesota Rules, part 9503.0045, subpart 1, item A. The AV walked onto University Avenue where a community person stopped their vehicle and led the AV back to the playground. The AV was unsupervised for one minute and was unharmed.

Although SP1 and SP2 each provided an example of a time when the gate did not close as expected, they also did not know if these instances were a malfunction or if they were due to user error, or accumulation of ice and snow. SP3 and the P were not aware of previous similar instances, and without additional information to state how often the gate did not close and for what reason, it was not determined if the facility or staff persons should have known and/or acted sooner to correct a malfunctioning gate.

SP1, SP2, and SP3 were on the playground at the time of the incident. SP2 and SP3 were inside the playground with other children and were not near the gate or aware it was open. Therefore, SP2’s and SP3’s responsibilities were mitigated.

SP1 walked through the gate one minute prior to the AV pushing it open. Although SP1 believed the gate closed and locked behind him/her, it did not. Instead, the gate immediately opened when the AV put his/her hands on it. The AV was then able to push the gate open without resistance.

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 the AV was unsupervised for one minute, it was determined SP1's actions were a nonmaltreatment mistake for the following reasons:

- 1) At the time of the incident, SP1 was performing duties identified in the center's childcare program plan. When SP1 entered the playground through the gate, SP1 walked through the gate and pulled the gate shut behind him/her glancing briefly back to look at the gate. It was reasonable for SP1 to believe that the gate had magnetized and working correctly;
- 2) SP1 was not determined responsible for a similar incident of maltreatment within the previous seven years;
- 3) SP1 was not determined responsible for a similar nonmaltreatment mistake under this paragraph within the previous four years;
- 4) The AV was uninjured and did not require medical care after the incident; and
- 5) Except for the period when the incident occurred, the facility and SP1 were both in compliance with all licensing requirements relevant to the incident.

The nonmaltreatment mistake to the AV by SP1 was not maltreatment.

Pursuant to Minnesota Statutes, section 260E.35, subdivision 6, paragraph (b), the investigative data in this report will be maintained by the Department of Human Services for a period of five years.

Action Taken by Facility:

The facility completed an internal review and determined that policies and procedures were adequate and followed. "We have implemented additional safety procedures, including that the gate from the playground will only be used to unload and load children on the bus, for emergency exit, and for once-a-week food delivery when children are not on the playground. Staff who are not with children will not use the gate. The gate has new hinges and will also be getting an alarm."

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

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

On July 11, 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.