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: 202401990

Date Issued: October 16, 2024

Name and Address of Facility Investigated:

The Goddard School
9295 Zane Avenue North
Brooklyn Park, MN 55443

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

License Number and Program Type:

1040162-CCC (Child Care Center)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that a staff person (SP) squeezed an alleged victim's (AV) ear leaving a "large" bruise on his/her right ear and that the SP "punched" the back of the AV's head on more than one occasion.

Date of Incident(s): February 27 and March 4, 2024

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 nine interviews conducted with the AV, the AV's family member (FM) who also worked at the facility, three facility management persons (P1, P2, P3), facility staff persons (P4, P5, and P6), and the SP.

The facility consisted of eight classrooms. After entering the building there were two hallways leading to the classrooms. There was a preschool classroom in the middle of the building where the hallways connected. The preschool classroom had two large windows facing each hallway.

The AV's enrollment file showed that the AV was three years old at the time of the incident and enrolled in the facility's preschool classroom with windows facing the hallway.

The FM stated that on March 4, 2024, P4 told him/her that on February 26, 2024, P4 saw the SP "punch" the AV in the back of the head. P4 said s/he told P1 about the incident on the day of the incident, but was told not to tell the FM. On an unknown date, the FM noticed a bruise on the AV's ear and when s/he asked the AV how the bruise occurred, the AV stated that the SP "squeezed" his/her ear. The FM stated s/he took the AV to a medical professional on March 5, 2024. The *After Visit Summary* provided by the FM stated that the issues addressed at the appointment for the AV, were adjustment disorder, post-traumatic stress disorder, and "confirmed" victim of physical abuse in childhood. The medical professional suggested that the FM schedule an appointment with a behavioral health specialist. On an unknown date, the AV met with a behavioral specialist who did not diagnose AV with adjustment disorder, post-traumatic stress disorder, or confirm that the AV was a victim of physical abuse.

The AV told this investigator that the SP was "mean" and that the SP "hit" the AV on his/her head. The AV demonstrated how the SP hit the AV's head by knocking the top of his/her head with his/her fist.

Facility documentation stated that on February 26, 2024, P4 talked to P1 and P2 and said that s/he heard the SP "threaten" to hit the AV. At that time, P1 and P2 advised P4 to offer the SP support by handling the AV's behavior. Later that morning, P4 returned to the office and told P1 and P2 that s/he saw the SP hit the AV on the head two times with his/her knuckles. P1 and P2 then talked to the SP about the incident and the SP denied that s/he hit the AV. The SP returned to the classroom but was told that "members of administration" would be visiting his/her classroom more often to ensure that s/he did not engage in negative behaviors with the children. On March 4, 2024, the FM talked to P1 and said that s/he saw the SP hit back of the AV's head with the SP's fist. The FM also told P1 that the AV had started using swear words and said that the AV heard the words from the SP.

Law Enforcement Records stated that on March 4, 2024, the FM contacted the law enforcement office. The FM told them that on February 27 or 28, 2024, the AV had a "very large weird looking" bruise on his/her right ear and when the FM asked the AV how the bruise occurred the AV said that "someone" squeezed his/her ear but did not say who or provide any further details due to his/her age and the FM did not pursue it any further. The FM said s/he had a photograph that showed a "fingernail scratch below" the AV's ear. [Note: The FM did not provide the photo to law enforcement or this investigator.]. There was no mention of a bruise in the description of the photograph. The FM also stated that P4 told the FM that on February 26, 2024, the SP "punched" the back of the AV's head on more than one occasion.

P1, P2, and P3 provided the following information:

- On February 26, 2024, P4 told P2 that s/he saw the SP "bopping" the AV on the head. P2 and P3 spoke to the SP about the incident and the SP stated that s/he was "frustrated" with the AV, lifted his/her hand like s/he was going to hit the AV, but did not do so. P2 and P3 sent the SP back to the classroom and decided to monitor the SP's behavior "closer" by walking past the classroom windows "more often."

- Prior to February 26, 2024, P2 and P3 had observed that the SP used "aggressive" voices towards the children but had not observed the SP be physically aggressive toward any child.

- P1, P2, and P3 each stated that they did not tell the FM about the initial incident on February 26, 2024, because they did not know if the SP actually hit the AV.

- On March 4, 2024, the FM told P1 and P3 that as s/he walked past the classroom windown, s/he saw the SP hit the AV with his/her fist. The FM said that s/he saw the SP "bop" the back of the AV's head with an upward swing motion and when the AV started crying, the SP comforted the AV.

- According to P3, the AV was an energic child who had a history of not following directions, not staying on task, and "hurting" his/her friends. Facility staff persons were working with the FM and the AV to focus his/her energy on positive behaviors rather than negative ones while at the facility and the AV was in the process of being screened for any possible diagnosis.

- P1, P2, and P3 were not aware of a bruise or a scratch on the AV's ear and were not aware that the AV had been using swear words that s/he said s/he heard from the SP.

P4 provided the following information:

- P4 worked in the preschool classroom with the SP and the AV. The SP was not "fond" of the AV because s/he did not like the AV's behaviors. The SP had a history of restricting the AV's activities in the classroom and swearing at the AV. P4 had discussed his/her observations of the SP's behavior with P2 and P3 and was instructed to show the SP how to interact with the AV and to "take over" working with the AV so the SP had limited interactions with the AV.

- On February 26, 2024, P4 saw the SP "knocked" the AV on the back of his/her head with the SP's knuckles. P4 stated that the SP took the AV to the corner of the classroom and hit the AV on the back of his/her head with his/her knuckles. The AV cried after the incident and ran to P4 for comfort.

- P4 told P2 and P3 about the incident and they asked P4 if s/he was "one hundred percent sure" s/he saw the SP hit the AV to which P4 replied, "Yes." P2 and P3 told P4 not to discuss the incident with anyone so P4 did not tell the FM about the incident.

- Later that day, P2 and P3 talked to the SP and then the SP asked P4 and P5 if they "had [his/her] back" and to not tell anyone that s/he hit the AV.

- On March 4, 2024, P4 saw the SP hit the AV on the top of the AV's head with the SP's fist. P4 did not know that the FM saw the SP hit the AV until a few hours later that day when the FM told P4 that s/he saw the SP hit the AV.

- On an unknown date, P4 saw a bruise on the AV's ear but did not know how the AV sustained the bruise. P4 did not know if the bruise was caused by the SP or another child or by other means. P4 had not seen the SP grab a child by the ear.

P5 provided the following information:

- P5 worked in the preschool classroom with the SP, P4, and the AV. According to P5, the AV did not listen to directions. P4 typically worked with the AV and provided "one on one" care to him/her because the AV did not listen to the SP or P5.

- P5 was aware that the SP did not like the AV and that the SP yelled at the AV "a lot." When the AV was not listening or hurting another child, the SP "grabbed" the AV's arm but not in an "aggressive" way to hurt the AV.

- P5 never heard the SP swear at the children but did hear the SP use swear words in the classroom. P5 never heard the SP call the AV a "piece of shit." P5 was not aware that the AV had a bruise or a scratch on his/her ear and did not know how the AV sustained a bruise or scratch on his/her ear.

- P5 stated that the SP "knocked" the AV on the top of his/her head with the SP's knuckles on more than one occasion but did not recall any specific dates or details of any incident. P5 did not think that the SP "knocked" the AV hard because the first time the AV laughed, but the second time the SP did it, the AV stopped laughing and started listening to the SP. P5 did not think that the SP "hit" the AV hard.

P6 provided the following information:

- P6 trained the SP when s/he was hired and observed that the SP "instantly" did not like the AV because the AV did not always listen to the SP's directions. P6 provided the SP with techniques on how to redirect the AV but the SP typically "threatened" to take activities away and swore at the AV when the AV did not listen. P6 spoke to P1, P2, and P3 about his/her observations of the SP's actions and was told that it would be monitored by P1, P2, and P3.

- On February 26, 2024, P4 told P6 that s/he saw the SP hit the AV on the back of the head and asked P6 for advice on what s/he should do. At that time, P6 instructed P4 to talk to P1, P2, and P3.

- P6 never saw the SP hit the AV and never saw a bruise on the AV's ear.

The SP provided the following information:

- On March 4, 2024, the FM standing in the window watching the AV and saw the AV crying in the classroom and the SP comforting the AV. The SP denied hitting the AV and stated that s/he "waved" his/her hands in the air around the AV to show that s/he was not touching the AV, but then "patted" the AV on the head to comfort the AV. The SP denied hitting the AV but stated that the FM's viewpoint "could look bad" when the SP raised his/her hand toward the AV.

- The SP denied hitting the AV on the top of the head and knocking the AV with his/her knuckles, but stated

that when s/he redirected the AV, s/he waved his/her hands in the air around the AV and that it might look like s/he was hitting the AV.

- The SP struggled working with the AV because the AV displayed multiple behaviors in the classroom and did not listen to the SP when s/he tried to redirect the AV. The SP stated that s/he did not hit the AV or cause a bruise or a scratch on the AV's ear.

- The SP denied swearing at the AV or using swear words around the AV.

The facility's *Behavior Guidance Policy* stated that at no time a child will be subjected to corporal punishment such as shaking, hitting, biting, pinching, humiliated, frightened, or verbally abused by a staff person. Children would never be punished for lack of participation in scheduled activities.

The facility's personnel files showed that the SP was trained on the facility's *Behavior Guidance Policy* and the Reporting of Maltreatment of Minors Act prior to the incident. In addition, P1, P2, P3, P4, P5, and P6 were also trained on the facility's *Behavior Guidance Policy* and the Reporting of Maltreatment of Minors Act prior to the incident.

Relevant Rules and/or Statutes:

Minnesota Rules, part 9503.0055, subdivision 3, item A, states 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:

On February 26, 2024, P4 saw the SP "knock" the back of the AV's head with his/her knuckles. On March 4, 2024, P4 and the FM saw the SP hit the AV on the back of his/her head with the SP's fist. The AV demonstrated to this investigator that the SP "knocked" him/her on his/her head with a closed fist. P5 who also worked in the same classroom as the SP stated that s/he saw the SP "knock" the AV on the top of his/her head with his/her knuckles on more than one occasion but did not know the specific dates or details. Although the SP denied hitting the AV, the SP's interactions as described by the AV, the FM, P4, and P5 were a violation of Minnesota Rules, part 9503.0055, subdivision 3, item A.

The FM stated that the AV had a bruise behind his/her ear on an unknown date and the AV told the FM that the SP squeezed his/her ear. Although it was possible that the SP squeezed the AV's ear without others seeing, given that there was no additional information provided that the SP squeezed the AV's ear, it was not determined whether the SP squeezed the AV's ear and caused the bruise.

Although the AV did not sustain an injury as a result of being hit on the top of the head and the SP denied that s/he hit the AV on the top of his/her head, given that more than one person observed the SP hitting the AV on the head on multiple occasions, there was a preponderance of the evidence that the SP's actions were not accidental and represented a threatened 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:
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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.

The SP was trained on the facility's *Behavior Guidance Policy* and the Reporting of Maltreatment of Minors Act prior to the incident. The SP was responsible for the 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 was not "serious" or "recurring." It was not determined whether the bruise on the AV's ears were a result of the SP's actions and the SP's interactions with the AV were considered a pattern of behavior and therefore a single incident.

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 stated that their policies and procedures were adequate but not followed at the time of the incident. The facility provided additional training to all staff persons. 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 October 16, 2024, the facility was issued a Correction Order for the violation outlined in this report, for failing to report maltreatment as required, for not maintaining staff distribution requirements, for not ensuring that all staff persons received orientation training prior to starting their job responsibilities, for separating children from the group as a form of behavior guidance, and for failing to record separations on a daily log.

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.