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: 202405159

Date Issued: November 27, 2024

Name and Address of Facility Investigated:

Bar None Residential Services
22426 Saint Francis Blvd
Anoka, MN 55303

Disposition:

Allegation One: Maltreatment not determined.

Allegation Two: Maltreatment determined.

Allegation Three: Maltreatment not determined.

License Number and Program Type:

1036848-CRF (Children's Residential Facility)

Investigator(s):

Carla Harvieux
Minnesota Department of Human Services
Office of Inspector General, Licensing Division
PO Box 64242
Saint Paul, Minnesota 55164-0242
carla.harvieux@state.mn.us
651-431-6616

Suspected Maltreatment Reported:

Allegation One: It was reported that on January 19, 2024, an alleged victim (AV1) left his/her bedroom and entered an alleged victim's (AV2's) bedroom. The AVs spent two hours in the bedroom and had consensual sexual intercourse. Two staff persons (SP1 and P1) were on shift when the incident occurred.

Allegation Two: It was reported that on February 6, 2024, SP1 saw the AVs kiss, permitted the AVs to be unsupervised in a facility storeroom, and saw AV2 use a vaping device or smoke a "joint," but took no action.

Allegation Three: It was reported that another staff person (SP2) permitted AV1 to use SP2's personal vaping device and brought vaping devices to the facility for AV1 to use.

Date of Incident(s): Prior to July 24, 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:

The incident in Allegation One was initially reported to the Department of Human Services (DHS) in January of 2024, but was not assigned for investigation at that time. However, in late July of 2024, DHS received information that on February 6, 2024, there was another incident (Allegation Two) regarding supervision concerns with SP1 and the AVs. Both the January and February incidents were assigned for further investigation in July of 2024. During the investigation of Allegations One and Two, this investigator obtained the information in Allegation Three, and it was added to this report.

Pertinent information was obtained during a site visit conducted on August 6, 2024; from documentation at the facility; and through interviews conducted with current and former facility staff persons (P1, P2, P3, and SP2). AV1 and AV2 were no longer at the facility, but AV1 and two of his/her family members (FM1 and FM2) provided information to this investigator regarding the facility which was included below. AV2 agreed to talk with this investigator by telephone, but when the investigator called AV2 at the scheduled time, no one answered the phone. AV2 did not respond to additional attempts to contact him/her. Two letters, one certified, were sent to SP1 requesting an interview with this investigator, and s/he responded to the letters and other attempts to contact him/her, but s/he did not schedule an interview. However, SP1 provided information in the facility's *Internal Review*, which was included below.

The facility provided services to youth based on their needs that included mental health therapies and case management. The doors of the AVs' bedrooms opened into a common area of the facility with couches where youths and staff persons might spend time together. There was a video recording system at the facility that recorded some common areas of the facility, and the videos were routinely reviewed by supervisory staff persons to ensure that the facility's policies and procedures were followed. The recordings from January and February of 2024 were reviewed by supervisory staff persons shortly after they became aware of the incidents, but in July of 2024, the recordings were no longer retained by the facility.

Facility documentation showed that AV1 had a history of substance use and of using vaping devices, but it was unknown how s/he obtained the devices. AV1 stated s/he had nicotine withdrawal symptoms (for which s/he received medication) and wanted to use a vaping device. AV1 had poor impulse control and might be vulnerable to sexual exploitation, but the *Vulnerability and Sexual Abuse Behavior Screen* completed for AV1 when s/he was admitted to the facility showed that AV1 had no history of sexual abuse and no history of sexually inappropriate behavior. No information showed whether AV1 had a history of providing inaccurate information. At the time of the incidents, AV1 was 14 years old. AV1 was social and liked to spend time with his/her friends.

AV2 was diagnosed with a physical disability and wanted to "fit in" with peers but had a history of making unsafe or impulsive decisions, which placed him/her at risk. AV2's *Placement Request* showed that s/he had no prior history of sexual abuse or sexually inappropriate behavior but was sexually active. No information showed whether AV2 had a history of providing inaccurate information. At the time of the incidents, AV2 was 16 years old.

AV2 loved his/her family members and was very loyal.

The AVs did not require additional or one-to-one supervision at the time of the incidents, and after the incidents occurred the facility updated their plans to alert staff persons of the incidents.

The facility's personnel and training records showed that staff persons interviewed for this report were trained on the Reporting of Maltreatment of Minors Act prior to the incident. SP1's *Orientation Checklist* was filled out and signed by the staff persons who trained SP1, but SP1 had not signed the *Checklist*. Documentation showed that SP1 completed a total of 80 training hours including five eight-hour office training days and four ten-hour "shadow shifts," which were all completed before SP1 worked his/her first "official shift." On January 25, 2024, SP1 was given a *Coaching to Achieve Form* for the January 19, 2024, incident. SP1's employment at the facility ended on February 12, 2024, because of the February 6, 2024, incident.

Allegation One: *It was reported that on January 19, 2024, AV1 left his/her bedroom and entered AV2's bedroom. The AVs spent two hours in the bedroom and had consensual sexual intercourse. SP1 and P1 were on shift when the incident occurred.*

Facility documentation, the facility's *Internal Review*, and interviews with this investigator provided the following:

- AV1 said that on the date of the incident, s/he left his/her bedroom and entered AV2's bedroom while SP1 was on shift. The AVs had sexual intercourse in the bedroom and was unsure whether SP1 was aware that s/he was in AV2's bedroom. The AVs were not unsupervised in their respective bedrooms on any other occasion, according to AV1.

- Information was consistent that P2 and P3, who were supervisory staff persons, reviewed recordings from the facility's video recording system and observed that at 1:11 a.m., on January 19, 2024, AV1 left his/her bedroom and entered AV2's bedroom, where s/he stayed for approximately one and a half hours. P1 and SP1 were on shift at the time, but P1 was in the facility office possibly counting medication when AV1 left his/her bedroom and was not responsible for supervising the AVs, according to P2. P2 talked individually with the AVs, and they each said that they had consensual sexual intercourse in AV2's bedroom. The facility completed an *Incident Report*, began investigating the incident, moved the AVs' bedrooms, and rearranged the furniture in the common areas to improve staff persons' line of sight into the common areas.

- In the facility's *Internal Review*, AV1 said that s/he was in AV2's bedroom for about an hour and thought that SP1 and P1 were unaware that s/he was in the bedroom. AV1 denied that s/he and AV2 had sexual contact and said that s/he and AV2 talked and hung out. AV2 said that AV1 was in his/her bedroom for about 15-20 minutes but s/he thought that SP1 and P1 saw AV1 in his/her bedroom but did not say anything. AV2 said that s/he and AV1 talked in the bedroom and provided no additional information.

- P2 stated that on the video recordings, s/he saw AV1 leave his/her bedroom, crawl to the couches, hide behind them, then make his/her way to AV2's bedroom in less than a minute. SP1 had just completed a room check on AV1 and other youths when AV1 exited his/her bedroom and SP1 was sitting in the common area with his/her back toward the AVs' bedroom doors when AV1 went from his/her bedroom to AV2's. P2 recalled that SP1 said that s/he had "no idea" that AV1 entered AV2's bedroom and that s/he closed the door to AV1's bedroom after making the bedroom check because AV1 asked him/her to.

- P1 said that the incidents with the AVs occurred a few months ago, but s/he recalled working with SP1 in January of 2024, when AV1 entered AV2's bedroom. P1 did some of the bedroom checks on that date and said that s/he completed checks by shining a flashlight onto the ceiling of the bedrooms but did not shine the flashlight directly onto the sleeping youths. P1 was unaware that the youths were together in AV2's bedroom until s/he saw the video of the incident, but it would have been easy for AV1 to hide in AV2's bedroom because AV1 was small, and there were many places for him/her to hide in a facility bedroom. When P1 saw the video of AV1 leaving his/her bedroom, s/he thought that AV1 dropped to his/her hands and knees to crawl out of the bedroom as soon as SP1 started to close the bedroom door and thought that SP1 would have noticed AV1 opening the door to crawl from his/her bedroom to AV2's bedroom. According to P1, SP1 looked down at AV1 as SP1 was closing the door.

- SP1 did not complete an interview with this investigator, but information s/he provided in the *Internal Review* showed that SP1 thought s/he completed bedroom checks on the date of the incident and thought the AVs were asleep in their beds. SP1 saw AV1 and AV2 each use the restroom at separate times during the overnight shift but did not think anything of it and did not see AV1 leave his/her bedroom or enter or leave AV2's bedroom. SP1 felt that s/he was not adequately trained and was "just kind of put on shift."

- P2 said that staff persons were to check on youths in their bedrooms four times an hour in a staggered pattern, by shining a flashlight on the youths to ensure they were in their beds and breathing. P1 was in the facility office, possibly doing a medication count when AV1 left his/her bedroom, but P1 completed some of the checks on the youths in their bedrooms during the approximately two-hour period that the AVs were together in AV2's bedroom. However, P1 did not use a flashlight to view the youths. P2 said that P1 told him/her that s/he forgot to use the flashlight but s/he could see the youths because they all had nightlights. P2 "wrote up" P1 and completed a "job coaching session" with him/her. P2 had no information whether AV1 placed items under his/her covers to make it appear that s/he was lying in his/her bed during the room checks and said that the AVs were not in AV2's bedroom for the entire night.

The FMs were upset that the bedrooms of youths of all genders were located in close proximity to each other on the same wing of the facility. In addition, the FMs each stated that AV1 provided consistent information over time to them, that a staff person whose identity they could not recall, provided AV1 and other youths with vaping devices at the facility. The FMs thought that staff persons did not provide the youths with adequate supervision and stated that when they voiced their concerns to supervisory and administrative staff persons whose identities they could not recall at the facility, their concerns were minimized, and their telephone calls not returned.

The facility's policy on *Resident Supervision and Safety* showed that staff persons were to supervise the residents and monitor resident movement to ensure and protect the health and safety of the residents. To determine the residents' supervision needs, the facility considered referral information regarding the resident, a vulnerability and sexual abusive screen for the resident, and a comprehensive resident substance use disorder evaluation. When the need for one-to-one supervision was determined, a staff member was assigned to supervise the resident and that staff person was not considered a part of the staff ratio. During awake hours when residents were out of a staff person's sight, staff persons were to complete a minimum of four random checks each hour not to exceed 20 minutes between checks. When residents were asleep, staff persons completed a minimum of four random checks each hour which must establish visual confirmation of the identity of the resident and breathing movement or other body movement,

Conclusion for Allegation One:

AV1 said that on the date of the incident, s/he and AV2 were unsupervised in AV2's bedroom and had sexual intercourse. Information provided by P2 and P3 and video recordings from the facility showed that shortly after 1 a.m., on January 19, 2024, the AVs spent about one and a half hours together unsupervised in AV2's bedroom. SP1 checked on AV1 in his/her bedroom, then when SP1 sat in the common area, AV1 crawled from his/her bedroom to AV2's bedroom, using the couches in the common area to conceal him/herself.

SP1 and P1 checked on the AVs in their bedrooms during the period when the AVs were in AV2's bedroom, but P1 did not consistently use a flashlight to make the checks. However, there were nightlights in the bedrooms, and it looked like the AVs were in their bedrooms. P1 thought that AV1 was small and could easily hide. The AVs provided conflicting information regarding whether they had sexual intercourse, but SP1 and P1 denied that they were aware of the AVs' actions. The facility investigated the incident, moved the AVs' bedrooms, and rearranged the furniture in the common areas to improve sight lines.

Although the AVs had sexual intercourse when they were unsupervised in AV2's bedroom and a flashlight was not used on some of the bed checks, given that bed checks were done, and that no information showed that SP1 or P1 were aware that AV1 was in AV2's bedroom, there was not a preponderance of the evidence as to whether staff persons were reasonably able to prevent the AVs from having unsupervised contact.

It was not 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; 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).

Allegation Two: *It was reported that on February 6, 2024, SP1 saw the AVs kiss, permitted the AVs to be unsupervised in a storeroom, and saw AV2 use a vaping device or smoke a "joint," but took no action.*

Facility documentation and interviews with this investigator provided the following:

- According to P3, while investigating the January 2024 incident and reviewing recordings from the video recording system, it was discovered that there were numerous concerns regarding SP1's actions on February 6, 2024.

- AV1 said that SP1 let AV1 and AV2 into the facility storeroom on multiple occasions to use vaping devices and told them to use the storeroom so that the AVs would not be on camera using the devices. Staff persons let AV1 use vaping devices because they knew that s/he was addicted to nicotine.

- Facility documentation showed that starting at 12:07 a.m., on February 6, 2024, and multiple times during the overnight hours, the AVs used a cell phone (which the AVs were prohibited from having) and posted pictures of themselves to a social media application. The AVs were in a common area of the facility, and at 1:46 a.m., on February 6, 2024, SP1 opened the door to the storeroom and permitted AV1 and AV2 to enter the room together and remain there without supervision for about 34 minutes. At 2:23 a.m., AV1 sat on AV2's lap in the common area, and there was "intimate touching" including kissing, rubbing, and

"grinding" which was observed by SP1, who took no action. At 3:54 a.m., AV1 removed his/her pajama pants, which left him/her dressed in underwear and a shirt, then sat on AV2's lap and rubbed his/her "bottom" on AV2 in the common area, who then took photos of AV1. SP1 was sitting at a table in the common area when these incidents occurred but did not intervene. The AVs used a vaping device at 3:34, 4:03, 4:17, 4:20, 4:22, and 5:48 a.m., and were seen blowing smoke into the air. At 4:23 a.m., the AVs entered the storage room again and remained in the room for approximately 45 minutes. At 5:13 a.m., the AVs again entered the storage room and remained there for about 35 minutes. The storage room door was closed on each occasion the AVs were in the room. SP1 witnessed each of these incidents but took no action.

- P3 immediately contacted SP1 to discuss the incidents, suspended SP1, and began investigating the incidents. The AVs' bedrooms were moved and AV2 was relocated to a different floor of the facility. In July of 2024, AV1 and AV2 no longer resided at the facility, the videos were unavailable, and SP1 was no longer employed at the facility. No information showed that the AVs sustained an injury during the incidents.

- P1 was unaware of the incidents that occurred in February of 2024, and had no information that the AVs were permitted to be unsupervised in a storeroom, or that the AVs used a vaping device, but added that the AVs and other youths at the facility frequently obtained vaping devices and staff persons took many devices from the youths. P2 was not involved in the investigation of this incident.

- SP1 did not complete an interview with this investigator, did not provide information regarding these incidents to P3, and was not asked about them in the facility's *Internal Review*.

Conclusion for Allegation Two:

A. Maltreatment:

AV1 said that SP1 permitted him/her and AV2 to use vaping devices at the facility and told them to use the devices in the storeroom so they would not be recorded by the facility's video recording system.

P3 reviewed a video recording from the facility's recording system which showed that on February 6, 2024, SP1 opened a storeroom door, permitted AV1 and AV2 to enter the room multiple times, and spend unsupervised time in the room. In the video, AV1 removed his/her pants, the AVs kissed and had other inappropriate physical contact, placed blankets on the storeroom floor, and then lay on the blankets. The AVs used a vaping device and blew smoke into the air. SP1 did not intervene with any of the incidents. In addition, the AVs used a facility cell phone and posted photos of themselves to a social media app.

AV1 had a history of using vaping devices and previously voiced concerns that s/he experienced nicotine withdrawal symptoms. The AVs were impulsive and AV2 had a history of making poor decisions which had negative consequences for him/her. After the incident, the AVs' bedrooms were moved and AV2 was relocated to a different floor of the facility. In July of 2024, the AVs no longer resided at the facility, the videos were unavailable, and SP1 was no longer employed at the facility.

SP1 did not provide information regarding these incidents. However, AV1 said that SP1 let the AVs use the devices

and information from P3 who reviewed the video recordings showed that SP1 permitted the AVs to have unsupervised and inappropriate contact at the facility and did not intervene when the AVs used a vaping device. Given this, that SP1 did not intervene and told the AVs to go into the closet to use the vape so they would be off camera, that the AVs were not of legal age to use or have vaping devices, the AVs' vulnerabilities, and that SP1 was trained on the facility's policies and procedures prior to the incidents, there was a preponderance of the evidence that SP1 did not provide the AVs with care that was required for their 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, 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.

SP1 was responsible for the care of the AVs when the incident occurred and was trained on the facility's policies and procedures and the Reporting of Maltreatment of Minors Act prior to the incidents.

SP1 was responsible for maltreatment of the AVs.

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 SP1 was responsible did not meet statutory criteria to be determined as recurring because his/her pattern of behavior was considered a single incident and was not serious because no information showed that the AVs were injured during the 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.

Allegation Three: *It was reported that SP2 permitted AV1 to use SP2's personal vaping device and brought vaping devices to the facility for AV1 to use.*

Facility documentation, the facility's *Internal Review*, and interviews with this investigator provided the following:

- AV1 said in an interview with this investigator, that SP2 brought vaping devices to the facility on multiple occasions for AV1 to use and let AV1 use his/her personal vaping devices. When one vaping device "ran out," SP2 gave AV1 another vaping device to replace it. SP2 let other youths use vaping devices, but AV1 could not identify the other youths.

- SP2 said that s/he was familiar with these concerns, and they had been investigated by the facility in an *Internal Review* in January of 2024. SP2 said that s/he used vaping devices and occasionally used them in

his/her personal car when s/he drove between locations on the facility campus. However, SP2 ducked in his/her car when using the devices to prevent youths on campus from seeing him/her. In addition, in January of 2024, AV1 and other youths asked SP2 and other staff persons to help them get vaping devices, but SP2 told the youths, "Of course not," and declined to assist them to obtain vaping services and did not share his/her vaping devices with them. SP2 thought that a staff person (P4) provided the above inaccurate information about him/her because s/he felt animosity toward SP2 when s/he was promoted to a position for which s/he and P4 each applied.

- The facility's *Internal Review* of the incident showed that on January 11, 2024, facility supervisory staff persons, including P2, received information that there was talk among the youths that SP2 permitted youths to use his/her personal vaping device in a facility office. In the *Internal Review*, SP2 acknowledged that s/he used vaping devices in his/her car at the facility, but the youths did not see him/her and SP2's vaping device did not match the description of the device provided by the youths. SP2 denied that s/he provided the youths with vaping devices or that s/he allowed the youths to use his/her vaping device/s.

- In the *Internal Review*, information from AV1 showed that s/he talked about using vapes with another youth at the facility who told AV1 that SP2 gave the youth a vaping device in the past, but AV1 did not provide additional information.

- There were no cameras in the room in which the incidents were alleged to have occurred. Staff persons were instructed to do "pocket checks" on AV1 after each visit with his/her family members because there were concerns that AV1 obtained vaping devices from family members or while in the community. It was determined that the facility's policies and procedures were not followed when SP2 used his/her vaping devices on campus but were adequate. SP2 was given coaching and a written corrective action for using substances on campus, and signed a substance use procedures acknowledgement form. The incidents were not similar to past events with the youths or SP2. The facility did not report this incident to the Department of Human Services.

Conclusion for Allegation Three:

Although AV1 told this investigator that SP2 provided him/her with vaping devices, given that statements from AV1 in the *Internal Review* showed that s/he had no first-hand information but relayed information from another youth, that there were no witnesses to the incident, and that SP2 denied that s/he gave vaping devices to AV1 or other youths, there was not a preponderance of the evidence as to whether SP2's actions posed a risk to youths at the facility.

It was not 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; 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).

Action Taken by Facility:

The facility completed an *Internal Review* which determined that its policies and procedures were adequate but were not followed. The facility planned that a supervisory staff person would work an overnight shift with SP1 and P1 individually to retrain them on shift expectations. Additional random video recording checks for SP1 and P1

were to be implemented, and all staff persons were instructed to remain within "close proximity" of the AVs to prevent future physical contact. The AV's bedrooms were moved to decrease the opportunities for them to have contact. On February 12, 2024, SP1's employment at the facility ended because of the allegations in this report and P1 left employment at the facility in April of 2024, for reasons unrelated to this report.

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

SP1 was not disqualified from providing direct care services as a result of the maltreatment determination in this report. However, SP1 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 SP1. The determination that SP1 was responsible for maltreatment is subject to appeal.

On November 27, 2024, the facility was issued a correction order for not reporting suspected maltreatment as required.

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.