

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: 202406866

Date Issued: February 6, 2025

Name and Address of Facility Investigated:

Goddard School, The
7201 Washington Ave S
Edina, MN 55439

Disposition:

Allegation One: Maltreatment determined as to neglect of an alleged victim by two staff persons.
Allegation Two: A nonmaltreatment mistake of an alleged victim by two staff persons was not maltreatment.

License Number and Program Type:

1101037-CCC (Child Care Center)

Investigator(s):

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Suspected Maltreatment Reported:

Allegation One: It was reported that an alleged victim (AV1) was in a classroom without staff person knowledge or supervision for approximately 30 minutes.

Allegation Two: During the course of the investigation, information was received that an alleged victim (AV2) was alone in a hallway without staff person knowledge or supervision for an undetermined amount of time.

Date of Incident(s):

Allegation One: August 7, 2024

Allegation Two: An unknown date in summer 2023 (likely August 30, 2023)

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 two site visits conducted on August 15 and September 6, 2024; from documentation at the facility; and through 12 interviews conducted with four supervisory staff persons (P1, P2, P3, and P4), seven facility staff persons (SP1, SP2, SP3, P5, P6, P7, and P8) (Note: P5 was also AV1's family member), and AV2's family member (FM).

This investigator met with AV1, but s/he did not provide any details to this investigator. Due to the length of time that had passed since the incident involving AV2, this investigator did not meet with AV2.

The facility was a stand-alone building with two levels. On the first level there were two infant classrooms, three toddler classrooms, two offices, and a multi-purpose room. The second level had four preschool classrooms. There were two sets of stairs leading from the first level to the second level, one set at the front of the facility, and one set at the back of the facility. At every door (including, but not limited to, each classroom door and doors at the top and bottom of the stairs) there was a laminated stop sign on the door stating, "Stop, did you conduct name to face threshold count?" These were in place at the time of both incidents.

The facility's *Supervision Policy* stated, "Supervision means when a program staff person is within sight and hearing of the child at all times." The facility's *Threshold Counts and Name to Face Checks Policy* stated, "As children leave the classroom with [staff persons], threshold count and name to face checks are conducted to ensure that all children are accounted for with the group. Threshold counts is the practice of a [staff person] counting the number of children in line and matching that number to the current number in attendance. Once the class reaches the final destination, a name to face check occurs. The [staff person] matches the name on the attendance record with the face of the child as s/he crosses the final threshold."

The facility's *Risk Reduction Plan* listed the two stairwells as identified risks related to the condition and design of the facility, but did not specify why. The policies and procedures developed to minimize those risks were, "All children must always be under adult supervision." The facility's *Child Care Program Plan* stated, "The staff person is present and accountable for the child's care, health, and safety of the child and will be within sight and hearing of the child."

Facility records showed that P1, P2, P3, P4, P5, P6, P7, P8, SP1, SP2, and SP3 were each trained on the facility's *Risk Reduction Plan*, the facility's *Child Care Program Plan*, and the Reporting of Maltreatment of Minors Act.

Relevant Rule and/or Statute

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.

During the course of this investigation, a third incident was reported in which another child (C) was found in the back stairwell after his/her classroom transitioned from the playground to a classroom upstairs with a staff person (P8). After interviewing several staff persons, it was determined that the C was left outside in the presence of two other staff persons (P6 and another staff person, possibly P7) and their class while the C's class transitioned upstairs. Although the C did not transition with P8 and his/her class, s/he was still supervised by P6 and another staff person, so there was no maltreatment or licensing violation noted.

Allegation One: It was reported that AV1 was in a classroom without staff person knowledge or supervision for approximately 30 minutes.

AV1 was 35 months old and enrolled in the second floor Lions (preschool) classroom at the time of the incident.

The facility's *Incident Report* showed that on August 7, 2024, around 8:50 a.m., the Lions class went downstairs to yoga (in the multi-purpose room) and name to face threshold counts were not completed or were inaccurate. AV1 was returned to the Lions class by another staff person. No additional detail was included about where AV1 was before s/he was returned to his/her class.

P6 provided the following information during his/her interview:

- On August 7, 2024, around 9:15 a.m., P6 lined up his/her class in the second floor hallway to go downstairs to the multi-purpose room for yoga. P6 heard AV1 crying in the Lions classroom and when P6 poked his/her head in s/he asked AV1 if AV1 was alone. AV1 nodded, "Yes." P6 had AV1 come to him/her and P6 gave AV1 a hug as SP1 and SP2 came up the stairs.
- AV1 hugged P6 tightly and seemed "scared and confused." SP1 and SP2 went over to AV1 and P6. SP1 and SP2 seemed "heartbroken" by what happened, and SP2 picked up AV1 and rubbed AV1's back. P6 then brought his/her class down to yoga.
- P6 was trained to perform name to face at each threshold passed during a transition, not to just count the children. Depending on which route a class took to get to the multi-purpose room, the transition involved doing a name to face four or five times. If a child was not signed in at the facility, s/he would not show up on the name to face application on the iPad, which was used to complete name to face checks.

P2 provided the following information during his/her interview:

- On August 7, 2024, P2 was walking along the hallway upstairs when SP1 stepped out of the Lions classroom and told P2 that AV1 was left in the classroom when their class went down to yoga for about 30 minutes. P2 looked in on AV1, who was sitting on SP2's lap, and it looked like AV1 had been crying. P2 then had SP1 go back into the classroom and P2 went downstairs to tell P1 what SP1 told him/her.

- P2, P1, and P3 had conversations with SP1 and SP2 about the incident. SP1 and SP2 were sent home for the remainder of the day. During the conversation with SP1, s/he asked if s/he could talk to P5 about what happened before P1, P2, and P3 did. When P5 came downstairs s/he stated that SP1 told P5 what happened and told P5 the length of time AV1 was alone was "very quick". P1, P2, and P3 told P5 that it was actually closer to 30 minutes, and then P5 was "upset." During the conversation with SP2, SP2 said AV1 was not signed in on the application the facility used to track attendance and therefore did not show up on the name to face.

P1 provided the following information during his/her interview:

- On the day of the incident, P1 was in the office when P2 entered and stated that AV1 was in the Lions classroom the whole time while the rest of the Lions class was at yoga. P1, P2, and P3 held conversations with SP1, SP2, and P5 about the incident. SP1 told them that it was "chaotic" because P5 was transitioning his/her class out of the Lions classroom, SP2 was not helping get the children lined up to go to yoga, and another family member was dropping off his/her child at that time and SP1 wanted to present him/herself as "under control" of the class. SP2 also told them it was chaotic, but that AV1 was in line.
- Staff persons were trained that during transitions, there should be a staff person in the front of the group doing name to faces, and another staff person at the back of the group. When conducting a name to face at each threshold, staff persons were to look at the name on the iPad, and then look at that child's face, for each child listed on the iPad. Staff persons could also count the children to confirm that everyone was present, but it was not required. P1 said SP1 and SP2 did not follow policies the day of the incident.

P3 provided the following information during his/her interview:

- On August 7, 2024, P3 arrived at the facility around 9:30 a.m. When s/he entered, P4 was seated at his/her desk and told P3 that SP1 and SP2 left AV1 in the classroom upstairs when they went downstairs to yoga.
- The facility used Camu (an application used to track attendance and communicate with families) and on the day of the incident, AV1 was checked into Camu at 8:50 a.m.
- When transitioning children, staff persons opened the roster on the Camu application and from there clicked on a name to face icon. An alphabetically ordered list of each child in the class then displayed, and once the whole class was checked in a text box appeared on the screen for staff persons to confirm they had all of the children. Camu data showed that during the incident, SP1 documented that AV1 was present during eight name to face checks before noticing that AV1 was not actually with the group.
- P3 reviewed video footage of the incident from a camera at the bottom of the back stairwell, which showed that three children came down the stairs, followed by SP2, and SP1 was a few steps behind SP2. SP2 started to open the door to the hallway and then SP1 moved around SP2 to hold the door while SP2 went through the doorway. P3 saw on the iPad that the name to face icon was open but could not hear what SP1 was saying. A family member and his/her child were the last two down the stairs and when

they walked by, SP1 went after them through the door and the door closed behind them.

P5 provided the following information during his/her interview:

- On the day of the incident, P5 arrived at the facility and brought AV1 upstairs to the Lions classroom. P5's class was combined with the Lions class at that time, so s/he took his/her group of children to P5's classroom. AV1 wanted to go with P5, so SP2 stepped in and helped keep AV1 with the Lions class. The Lions class was lining up to go to yoga and there were some children pushing and shoving.
- Later, SP1 told that AV1 had been left alone, but SP1 made it sound like only five to ten seconds, and that SP1 grabbed AV1 "right away." However, P3 told P5 that AV1 was alone in the room for 30 minutes.
- Staff persons were trained to conduct a name to face before leaving the classroom, and at each threshold passed through during the transition. There were signs on each door for reminders.

SP1 provided the following information during his/her interview:

- On August 7, 2024, (a Wednesday) SP1 and SP2 were in the Lions classroom with all of the other classrooms in the morning. On Wednesday mornings at 8:45 a.m., the Lions class had yoga downstairs. On that date, P5 dropped off AV1 at 8:45 a.m. (facility documentation supported AV1's drop off at that time) so the class was going to be late getting to yoga. P5 left with his/her class and SP1 started calling the Lions class to line up in the hallway.
- AV1 was at the front of the line while SP1 called names and when AV1's name was called, s/he went into the hallway. Another child was being dropped off at that time and was having a hard time letting go of his/her family member, so the family member stated s/he would walk with the group. As SP1 turned back to lead the line, the other children were not in line so SP1 tried to get the children back in line. SP1 stated that SP2 was not helping, and neither one of them noticed that AV1 "snuck" back into the classroom. SP1 did a "quick" name to face, and the group went downstairs.
- The group arrived downstairs to yoga "late" and SP1 tried to regain his/her focus and took pictures of the group doing yoga to send to family members. Once yoga was done, SP1 and SP2 took the children back upstairs and when SP1 opened the door leading from the stairs into the hallway, SP1 saw AV1 with P6 and AV1 was crying. SP1's "heart dropped" and s/he was "at a loss for words."
- SP1 said according to his/her training, a name to face should have been completed four times on the way to yoga class (in the hallway outside the classroom, at the door at the top of the stairs, at the door at the bottom of the stairs, and upon arrival at yoga class), and another three times (in reverse order) between yoga class and when s/he saw AV1 in the hallway.
- SP1 said s/he "dropped the ball" when s/he did name to faces during the incident by just calling out each name on the class roster, but not looking at each child's face to ensure they were present. SP1 thought another child might have responded when SP1 called AV1's name out.
- The class went downstairs late to yoga so SP1 thought the AV1 was unsupervised for 20 minutes.

SP2 provided the following information during his/her interview:

- On August 7, 2024, SP2 went into the Lions classroom in the morning. After breakfast, s/he assisted children in the restrooms. While SP2 was still helping with restrooms, P5 dropped off AV1 and P5 left the Lions classroom with P5's group of children. After P5 left with his/her class, SP2 went into the hallway as SP1 called names off from the tablet. Some children (including AV1) tried to exit the classroom before their name was called, so they had to go back inside the classroom until their name was called.
- While SP1 was in the process of conducting a name to face, a family member dropped off a child. SP2 led the class downstairs and SP1 was in the back of the line trying to help the child who was getting dropped off. It was "a little chaotic" but SP1 did perform a name to face at the door at the top of the stairs and again when the class went into the room for yoga class. After yoga class was done, the class proceeded back upstairs and that was when SP2 saw that AV1 was with P6. AV1 was "lightly crying" at that time.
- SP2 was trained to call children's names, have them line up in the hallway while counting the children's heads (SP2 stated that SP1 did not do that on the day of the incident), and then complete a name to face at each threshold.

This investigator reviewed video footage of the back stairwell from August 7, 2024, and noted the following:

- Three children went down the stairs followed by SP2. Once SP2 was at the bottom of the stairs, s/he opened the door and stood with it slightly propped open to block children from going through the door.
- SP1 walked by several children on the stairs and took SP2's place at the door, and SP2 passed through the door. SP1 had the tablet in his/her hand and proceeded to call the children's names alphabetically. SP1 called two names and looked up to see those children, and then by the third name SP1 started calling names but did not always look to match the face to the name (including when SP1 called AV1's name). Children started walking through the doorway toward SP2.
- A family member walked with his/her child and were the last to come down the stairs. When they walked through the door, SP1 followed them, and the door shut behind SP1.
- In total 12 children went through the door but SP1 called 13 names (including AV1's name) during the name to face.

Conclusion for Allegation One:

A. Maltreatment:

Consistent information was provided that around 8:50 a.m. on August 7, 2024, SP1 and SP2 led a group of children from the upstairs Lions classroom to the downstairs multi-purpose room to attend a yoga class. Before leaving the Lions classroom, SP1 called the children's names and the class lined up in the hallway. SP1 and SP2 each stated that during the transition, SP1 conducted a name to face at each threshold. Around 9:15 a.m., P6 walked by the Lions classroom with his/her class and found AV1 alone in the classroom, crying. AV1 was with P6

when SP1 and SP2 returned upstairs after the Lions class yoga session ended.

SP2 said s/he thought AV1 had not been signed in and therefore did not show up on the roster when names were being called during name to face checks, and SP1 thought another child might have responded when s/he called AV1's name during checks. However, SP1 acknowledged that s/he "dropped the ball" and did not actually look at the face of each child whose name s/he called during name to faces. In addition, video footage showed the Lions class at the bottom of the back stairwell during the transition from the Lions classroom to the multi-purpose room, and in the video, SP1 called 13 children's names (including AV1's) but did not appear to notice that only 12 children were with the group; and video also showed that SP1 did not consistently look to match a face to each name s/he called, including when s/he called the AV's name. Furthermore, information from P3 showed that SP1 documented that AV1 was present during eight name to face checks before learning that AV1 was not with the group.

AV1 was unsupervised in the Lions classroom for approximately 30 minutes, which was a violation of Minnesota Statutes, section 245A.02, subdivision 18, and Minnesota Rules, part 9503.0045, subpart 1, item A, and the facility's *Risk Reduction Plan* and *Child Care Program Plan*. While AV1 was unsupervised, SP1 and SP2 were not present to intervene in case of injury or emergency. Therefore, there was a preponderance of the evidence that there was a failure to supply AV1 with necessary care, and a failure to protect AV1 from conditions or actions that seriously endangered AV1's physical or mental 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. 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 and SP2 were responsible for the supervision of AV1 at the time of the incident and SP1 and SP2 were each trained on the facility's *Risk Reduction Plan*, the facility's *Child Care Program Plan*, and the Reporting of Maltreatment of Minors act. SP1 and SP2 were each responsible for the maltreatment of AV1.

C. Recurring and/or Serious Maltreatment:

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

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

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

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

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

It was determined that the substantiated neglect for which SP1 and SP2 were responsible did not meet statutory criteria to be determined as recurring or serious as it was a single incident and AV1 sustained no injuries.

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 Two: During the course of the investigation, it was reported that AV2 was alone in a hallway without staff person knowledge or supervision for an undetermined amount of time.

AV2 was three years old and enrolled in a preschool classroom at the time of the incident.

The facility's *Fire Drill Log* showed that there was a fire drill on August 30, 2023, at 1:10 p.m. that was noted to be the yearly nap time drill. It was documented that it took 12 minutes to evacuate.

Initially the FM did not remember an incident regarding AV2 during a fire drill. The FM later called back and left this investigator a message stating that after speaking with his/her significant other, they did remember receiving information about a fire drill incident, "a year ago," but they did not remember the details.

SP3 provided the following information during his/her interview:

- On an unknown date sometime between July and October 2023, SP3 and SP2 were in a classroom when a fire drill went off. They performed a name to face count prior to leaving the classroom, and SP3 was at the front of the line leading the class outside while SP2 was at the back of the line. Once outside, SP3 walked backwards and called out children's names. SP3 stated someone responded, "Here," when SP3 called out AV2's name. Once they reached their designated area, SP3 counted and counted 20 children. SP3 asked SP2 how many children s/he counted and SP2 confirmed 20 children.
- P2 came out to check how many children staff persons had with them, and then SP3 looked up toward the building and thought s/he saw a child in the window of his/her classroom. SP3 and SP2 went back into the building and SP3 found AV2 in the hallway alone. AV2 told SP3 s/he got "scared" and went back to get his/her "lovie."
- SP3 was scared and "yelled" at AV2 that s/he needed to stay with the group. SP3 realized that as they were following another class of children outside there was another child with similar hair coloring and clothing as AV2, so SP3 thought that child was counted instead of AV2. SP3 thought AV2 was unsupervised for approximately five minutes during the incident.
- At the time, SP3 thought P1 and P2 reported the incident, but P1 later told SP3 that s/he did not report the incident. P1 advised SP3 to "lie" to this investigator and communicated to SP3 that "If they do really press you, you can say that the kids were really slow going down the stairs due to their age and development so [AV2] was at the top, and you needed assistance in getting [him/her] down. Simple as that. And the rest you don't remember."
- SP3 talked with all the families at pick up and told them to practice fire drills at home because they had conducted one that day and a child had gone slower and was left in the classroom. SP3 talked with AV2's family members who stated that they had not practiced fire drills at home, but that it was not "uncommon" for AV2 to run and hide.

During his/her interview, SP2 stated that on an unknown date during nap time, s/he was working with SP3 when the fire alarm went off. SP2 said they completed a name to face before going outside. The children were going slower than usual because it was nap time. When SP2 and SP3 got outside they counted 20 children, but one of

them was from another group, so one child (SP2 was unable to recall AV2's name) from SP2 and SP3's group was not accounted for. SP2 did not remember who found the child, but thought it was P2 when s/he completed a check of the classrooms. SP2 was not sure if the child (likely AV2) was left in the building or went back into the building because AV2 wanted his/her blanket. SP2 thought AV2 was alone "less than five minutes" during the incident.

SP1 provided the following information during his/her interview:

- On an unknown date in summer 2023, SP1 was working in different classroom with another staff person when they brought their class inside after a fire drill. When SP1 passed the Lions classroom, s/he saw AV2 inside the classroom crying.
- SP1 initially thought, "Wow, that group got back inside quick," but once SP1 and the staff person s/he was working with made it back to their classroom, SP1 realized that AV2 had been alone. SP1 left his/her classroom to go back to the Lions classroom to check on AV2.
- As SP1 approached the classroom, P6 also saw AV2 in the classroom and went inside ahead of SP1. SP1 waited until the office was notified of the incident. Later that day, SP3 was "all worked up" over what happened.

P2 provided the following information during his/her interview:

- In summer 2023, the facility had moved a classroom upstairs for children ages 30 to 36 months old. In August 2023, there was a fire drill and SP3 was the only staff person in that classroom at that time and was within ratio.
- P2 reviewed video footage of the incident and observed that as SP3 transitioned the children downstairs, s/he was at the front of the line and was at the bottom of the stairs holding the door open to go outside, but AV2 was still at the top of the stairs. That was when SP1 found AV2 and SP1 brought AV2 down the stairs to SP2 during the fire drill, not after. P2 thought it was "ten seconds" that AV2 was not in SP3's supervision (because SP3 could not see AV2 at the top of the stairs from the bottom of the stairs).
- P1 was aware of the incident and made the decision to not report to the Department of Human Services as required. However, P1 told P2 that when this investigator asked P1 about the incident, P1 told this investigator that s/he did not remember the incident.

P1 provided the following information during his/her interview:

- Initially, P1 stated that s/he was not aware of the incident, and then later P1 said s/he thought SP3 was working alone with a class upstairs during the fire drill in question. When the fire drill happened AV2 was at the back of the line, and due to his/her age and development s/he had not made it down the stairs when the other class came by and saw him/her. P1 did not remember if SP3 was standing by the door at the bottom of the stairs when AV2 was brought down or if s/he had already gone outside.
- At the time of the fire drill in question, the age group in AV2's classroom was two and a half years old and

younger. The facility completed an *Internal Review* for this incident and stated that for this particular age group, the [children] did not have the appropriate development to navigate the stairwell, so it was difficult for just one [staff person] to assist all of them down. The facility changed the age group for the upstairs level classrooms to 33 to 36 months of age after the incident, and moved younger children to the lower level classrooms.

- At the time of the incident, the facility cameras did not record the whole day if the Wi-Fi was “glitchy,” and on that day they “did not get that half of the day,” so they did not get much information from the cameras.
- P1 reached out to SP3 to verify that P1 provided this investigator with the correct contact information and they “did not remember everything that happened.” P1 stated that s/he did not ask anyone to “lie” and that P1 wanted to clarify what happened, since s/he did not remember every single detail.
- P1 stated that s/he did not remember why the incident was not reported, but that if someone realized that AV2 was alone on the stairs, they should have reported it because staff persons were mandated reporters.

P5 provided the following information during his/her interview:

- On an unknown date, P5 was on his/her break and was in an upstairs closet gathering supplies when a fire drill took place. P5 did not hear the fire drill while s/he was inside the closet, but when P5 came out of the closet s/he saw SP2 and SP3 come up the stairs and then SP3 was “hysterically” saying to AV2, “Don’t do that again.” P5 was not sure what was going on at that time or what SP3 was talking to AV2 about. P5 gave SP3 a hug and went back to his/her classroom.
- P5 was told by P1 that this investigator heard about other incidents that had occurred and P1 asked P5 to reach out to SP3 to see what SP3 was going to say to this investigator. P5 spoke with SP3 and told SP3 to tell this investigator the truth, which was that during a fire drill, AV2 ran back to get his/her blanket or “plushie”. SP3 told P5 s/he did not want to “get in trouble.”

During his/her interview, P6 stated that s/he was unaware of a child being unsupervised during a fire drill.

Conclusion for Allegation Two:

SP3 and SP2 provided information that on an unknown date in the summer of 2023, (likely August 30, 2023, based on the facility’s *Fire Drill Log*) SP3 and SP2 were upstairs with their class when a fire alarm went off. They lined up

the children and performed a name to face count. Inconsistent information was provided about what happened next:

- SP3 said that once SP2 and SP3 reached their designated area outside, SP3 and SP2 each counted 20

children. SP3 looked up and thought s/he saw a child in the window of his/her classroom. SP3 said s/he and SP2 returned to the building and found AV2 in a hallway alone, and AV2 told them s/he got "scared" and went back to get his/her "lovie." SP3 was scared and "yelled" at AV2 to stay with the group. SP3 thought AV2 was unsupervised for about five minutes.

- SP2 also said that once SP2 and SP3 reached their designated area outside, they each counted 20 children. However, SP2 thought AV2 was found by P2 when s/he completed a walk through. SP2 thought AV2 was unsupervised for "less than five minutes."
- SP1 stated that s/he walked past AV2's classroom when s/he went back into the building after the fire drill and saw AV2 inside a classroom crying. Once back in his/her classroom, SP1 realized AV2 was alone. SP1 went back to AV2's classroom and at that time P6 also arrived and went inside the classroom and SP1 waited until someone informed the office what had happened.
- P6 stated that s/he was not aware of the incident.
- P5 saw SP3 "hysterically" saying, "Don't do that again," to AV2 as SP2 and SP3 came up the stairs after a fire drill on an unknown date.
- P1 and P2 each stated that they thought SP3 was alone and within ratio during the fire drill. When SP3 led the class downstairs, due to AV2's age and development, s/he was still at the top of the stairs and SP3 was at the bottom, when SP1 walked by and saw AV2 and then SP1 brought AV1 downstairs.

Although information was inconsistent as to how long AV2 was unsupervised during the incident, SP3 and SP2 had no reason to exaggerate their information, and P5 provided information that corroborated SP3's account. Meanwhile, P1 and P2 had reason to minimize the incident, and SP3 and P2 each provided information that P1 knowingly provided inaccurate information to the DHS investigator. Therefore SP3's account of the incident was determined to be the most credible and it was more likely than not that AV2 was unsupervised for approximately five minutes, which was a violation of Minnesota Statutes, section 245A.02, subdivision 18, and Minnesota Rule, part 9503.0045, subpart 1, item A.

Minnesota Statutes, section 260E.30, subdivision 3, stated 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 profession 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.

SP2's and SP3's actions were determined to be a nonmaltreatment mistake for the following reasons:

- (1) at the time of the incident, SP2 and SP3 were performing duties as required in the facility's policies by participating in a fire drill;
- (2) SP2 and SP3 had not been determined responsible for a similar incident that resulted in a finding of Maltreatment (note: although SP2 was determined responsible for maltreatment in Allegation One of this report, because the incident in Allegation Two occurred approximately one year before the incident in Allegation One, at the time of the incident in Allegation Two, SP2 had not been determined responsible for maltreatment in a similar incident);
- (3) SP2 and SP3 had not been determined to have committed a similar nonmaltreatment mistake under this paragraph;
- (4) there were no injuries to AV2 as a result of the incident; and
- (5) except for the period when the incident occurred, the facility, SP2, and SP3 were in compliance with all licensing requirements relevant to the incident.

The nonmaltreatment mistake to AV2 by SP2 and SP3 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 found their policies and procedures adequate but not followed by SP1 and SP2. After the fire drill the facility moved their older toddler aged children to a downstairs classroom noting that those children did not have the appropriate development to navigate the stairs during a fire drill. SP1, SP2, and SP3 no longer worked at the facility.

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

Allegation One:

SP1 and SP2 were not disqualified from providing direct care services as a result of the maltreatment determination involving AV1. However, SP1 and SP2 were each 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 disqualification. The determination that SP1 and SP2 were each responsible for maltreatment is subject to appeal.

Allegation Two:

SP2 and SP3 were not determined as a perpetrators of maltreatment of AV2 because the Department of Human Services found that the incident for which SP2 and SP3 were responsible met the criteria to be determined a nonmaltreatment mistake. SP2 and SP3 were each notified by the Office of Inspector General that any future incident of possible neglect of an alleged victim for which SP2 and SP3 are responsible might not be considered a nonmaltreatment mistake.

Licensing Violations:

The license holder was ordered to forfeit a fine of \$600 for the following reasons. The Order to Forfeit a Fine is subject to appeal.

- It was determined that false or misleading information was provided during the investigation. The license holder was ordered to forfeit a fine of \$200 for providing false or misleading information to this investigator.
- It was determined that facility mandated reporters had knowledge of an alleged incident of maltreatment and did not report the incident as required. The license holder was ordered to forfeit a fine of \$200 for failure to report maltreatment.
- It was determined that a background study violation occurred. The license holder was ordered to forfeit a fine of \$200 for the background study violation.

On February 6, 2025, the facility was issued a Correction Order for the violations outlined in this report related to supervision.

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.