STATE OF MINNESOTA
IN COURT OF APPEALS
A16-1500

In the Matter of the Appeal by
Mayflower Early Childhood Center of the
Determination of Maltreatment and Order to Pay a Fine.

Filed April 10, 2017
Reversed
Kalitowski, Judge*

Department of Human Services
File No. 82-1800-32893

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Considered and decided by Reilly, Presiding Judge; Stauber, Judge; and Kalitowski, Judge.

U N P U B L I S H E D O P I N I O N

KALITOWSKI, Judge

Relator Mayflower Early Childhood Center challenges respondent commissioner of human services's determination that Mayflower was culpable for maltreatment based on neglect, and imposition of a $1,000 fine. Following a contested-case hearing, an administrative-law judge (ALJ) recommended that the maltreatment determination be

* Retired judge of the Minnesota Court of Appeals, serving by appointment pursuant to Minn. Const. art. VI, § 10.

reversed and the fine rescinded, but the commissioner affirmed both. Relator argues that (1) the commissioner erred as a matter of law by using a violation of licensing supervision rules to support a maltreatment violation and (2) the commissioner's decision is not supported by substantial evidence. Because the commissioner's decision is not supported by substantial evidence, we reverse.

D E C I S I O N

"Administrative-agency decisions enjoy a presumption of correctness and may be reversed only when they are arbitrary and capricious, exceed the agency's jurisdiction or statutory authority, are made upon unlawful procedure, reflect an error of law, or are unsupported by substantial evidence in view of the entire record." *In re Revocation of Family Child Care License of Burke*, 666 N.W.2d 724, 726 (Minn. App. 2003). We defer to the agency's factual findings, but review de novo "the interpretation of statutes and their application to undisputed facts." *Mattice v. Minn. Prop. Ins. Placement*, 655 N.W.2d 336, 340 (Minn. App. 2002), *review denied* (Minn. Mar. 18, 2003). "The relator has the burden of proof when challenging an agency decision . . . ." *Minn. Ctr. for Envtl. Advocacy v. Minn. Pollution Control Agency*, 660 N.W.2d 427, 433 (Minn. 2003).

I.

The present case arises out of two incidents of inappropriate touching involving very young children supervised by Mayflower while on Mayflower's playground. Mayflower argues that the commissioner erred as a matter of law by using the licensing supervision rules as a basis for a maltreatment determination. We disagree.

The legislature has provided that the public policy of Minnesota "is to protect children whose health or welfare may be jeopardized through physical abuse, neglect, or sexual abuse." Minn. Stat. § 626.556, subd. 1(a) (2016). Under the Minnesota Maltreatment of Minors Act, maltreatment includes neglect. *Id.*, subd. 10e(f)(2) (2016). Maltreatment by neglect includes "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" and "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." *Id.*, subd. 2(g)(1), (2) (2016).

Minnesota law requires childcare-license holders to conduct an internal review "when the facility has reason to know that an internal or external report of alleged or suspected maltreatment has been made." Minn. Stat. § 245A.66, subd. 1(1) (2016). In addition, childcare centers must "develop a risk reduction plan that identifies the general risks to children" and such a plan "must include specific policies and procedures to ensure adequate supervision of children at all times as defined under section 245A.02, subdivision 18, with particular emphasis on . . . supervision during outdoor play." *Id.*, subd. 2(a), (f)(4) (2016). "'[S]upervision' means when a program staff person is within sight and hearing of a child at all times so that the program staff can intervene to protect the health and safety of the child." Minn. Stat. § 245A.02, subd. 18 (2016).

Because Mayflower is a licensed childcare center, it must follow the childcare-licensing rules, including the supervision provisions outlined above. The ALJ correctly acknowledged that a supervision violation does not necessarily constitute maltreatment.

Rather, maltreatment by neglect occurs when a childcare center fails to provide care "required for the child's physical or mental health" or "to protect a child from conditions or actions that seriously endanger the child's physical or mental health" when the center is able to provide such care or protection. Minn. Stat. § 626.556, subd. 2(g)(1), (2). Thus, although a violation of the licensing supervision rules could be maltreatment, every such violation does not necessarily constitute maltreatment.

Although Mayflower is correct that the commissioner cited the licensing supervision standards provided by chapter 245A in affirming the maltreatment determination, the commissioner did not rely on the supervision standards in affirming the determination. Rather, the commissioner reviewed the supervision rules to establish that Mayflower was required to develop a risk-reduction plan that specifically included provisions regarding adequate supervision of children, including during outdoor play; that Mayflower was required to review its policies after becoming aware that children were engaging in inappropriate touching; and that Mayflower was required to implement a corrective-action plan.

The commissioner viewed the level of care and protection provided to the children in light of the review and corrective-action plan required of Mayflower and determined that the lack of supervision provided by Mayflower constituted maltreatment. Because the commissioner did not rely on the statutes regarding supervision in affirming the maltreatment determination, we conclude that the commissioner did not err as a matter of law.

II.

Mayflower argues, and we agree, that the commissioner's decision is not supported by substantial evidence. Mayflower contends that it provided appropriate supervision and that the commissioner improperly relied on the mere occurrence of a second incident as evidence that Mayflower provided inadequate supervision.

> A decision is supported by substantial evidence when it is supported by (1) such relevant evidence as a reasonable mind might accept as adequate to support a conclusion; (2) more than a scintilla of evidence; (3) more than some evidence; (4) more than any evidence; or (5) the evidence considered in its entirety.

Minn. Ctr. for Envtl. Advocacy v. Minn. Pollution Control Agency, 644 N.W.2d 457, 464 (Minn. 2002).

The maltreatment determination stems from two incidents that occurred on Mayflower's playground. On July 14, 2015, a child reported to Mayflower's aftercare co-coordinator that he had observed two other children, five-year-old AV-1[1] and six-year-old AV-2, playing an inappropriate "touching game," which involved the children touching each other's genital areas. The incident occurred behind recycling and trash bins that were stored at the perimeter of Mayflower's playground. When interviewed, AV-1 and AV-2 each stated that it was the other child's idea to play the game and reported that they had played the game with three other children "on a different day."

[1] The children involved in this case are referred to by a number and the initials "AV." "AV" is an abbreviation for alleged victim.

Following this incident, Mayflower instructed staff to be vigilant when supervising the playground, told staff to move around the playground in order to observe all areas of it, and identified lilac bushes and an opaque yellow tube as areas of the playground to be particularly aware of because they were places where children could not be seen.

The second incident occurred on July 27, 2015. On that day, AV-3 reported that AV-1 had pulled her pants down and put his finger in her vagina while they were in the yellow tube on the playground. Neither the precise time nor the duration of the incident is known, but four different staff members were supervising the playground at various times when the incident may have occurred. And at all relevant times Mayflower was in compliance with licensing standards regarding the ratio of adults to children.

The Minnesota Department of Human Services (the department) issued Mayflower a maltreatment determination based on neglect regarding the second incident due to inadequate supervision. But the ALJ found that the department failed to identify what behavior, action, or omission was neglectful. When asked at the hearing what the maltreatment determination was based on, the department investigator explained that Mayflower was aware of the first incident but inappropriate touching occurred a second time. The investigator, when asked to identify the specific failure of Mayflower, testified that "[t]here was not enough supervision to prevent [inappropriate touching] from occurring again."

But to sustain the department's maltreatment by neglect determination, the department must present substantial evidence that Mayflower failed to provide a child with care required for the child's physical or mental health when Mayflower was reasonably

able to do so or that Mayflower failed "to protect a child from conditions or actions that seriously endanger the child's physical or mental health when reasonably able to do so." Minn. Stat. § 626.556, subd. 2(g)(1), (2). Essentially, the department was required to produce substantial evidence that (1) Mayflower failed to provide care to the children or failed to protect them and (2) Mayflower was reasonably able to provide such care or protection.

Both the ALJ and the commissioner found that Mayflower made extensive efforts to prevent recurrence of the first incident. On the day of the first incident, the recycling and trash containers were removed to eliminate the hidden area where the first incident had occurred, and Nanci Olesen, Mayflower's director, contacted the parents of the children involved. That day, Olesen sent an email to all staff alerting them to the incident and informing them that she would be addressing the incident with them the next day in one-on-one meetings. Also, Olesen spoke to the teacher of the students known to be involved in the first incident and identified the students to Mayflower's aftercare staff.[2] Olesen emphasized to the staff the importance of moving around the playground when supervising the children and addressed the incident in a weekly memorandum that was mandatory reading for all staff members. Olesen spoke with peers in other childcare centers for guidance on how to respond to the incident. Mayflower ordered books for addressing appropriate touch with children, and teachers discussed appropriate touch with the children

[2] Mayflower's program includes an aftercare program that begins at 3:30 p.m., when the preschool day ends. The first incident occurred during aftercare.

in small groups. And Mayflower was in compliance with licensing ratio standards when both incidents occurred.

The ALJ concluded that the maltreatment determination was not supported because the department did not show that Mayflower failed to provide the children with necessary care or protection, reasoning that the department could not point to any act or omission that was neglectful and that Mayflower was in compliance with all of the licensing rules and took immediate steps to address the first incident. The ALJ noted that in hindsight Mayflower could have taken more steps, but concluded that "the steps [Mayflower] did take were reasonable given the concerns it had to balance, watching the children but not villainizing any particular child, and the facts it had at the time."

The commissioner adopted the ALJ's findings regarding Mayflower's efforts, but rejected the ALJ's recommendation that the maltreatment determination be reversed, essentially concluding that the department's maltreatment determination was substantiated because Mayflower could have reasonably taken other steps that would have prevented the second incident. Specifically, the commissioner noted that Mayflower could have removed the yellow tube, modified its policy concerning children's access to the tube, or established an explicit policy regarding supervision of the playground's hidden spaces.

On appeal, the commissioner points to a number of steps that Mayflower could have taken, including informing all of its staff that AV-1 was one of the children involved in the first incident, and increasing staff supervision of AV-1. But based on the record, some of the actions suggested by the commissioner were not reasonable, given the knowledge Mayflower had at the time. For example, the department suggests that Mayflower should

have increased staff supervision of AV-1. But Mayflower would have also had to increase staff supervision of AV-2 and the other children that AV-1 and AV-2 identified as having played the "touching game" because Mayflower did not know who was the instigator of the first incident. And such increased supervision would necessarily detract from the ability of the staff to supervise the remaining children. Mayflower could have told all of the staff members that AV-1 and AV-2 were the two children involved in the first incident, instead of just the aftercare staff and the teacher of AV-1 and AV-2. But, given that Mayflower was unaware whether AV-1 or AV-2 was the instigator and had information concerning other children's involvement in the "touching game," it was not unreasonable that Mayflower did not alert each and every staff member concerning AV-1 and AV-2.

Importantly, the commissioner improperly relied on possible measures that might have prevented the second incident in determining whether Mayflower failed to provide care for or protect the children when it was reasonably able to. Using hindsight, the commissioner identified steps that Mayflower could have taken that would have prevented the second incident from occurring. But to determine whether the maltreatment determination is supported by substantial evidence, the question is whether Mayflower failed to provide care to or failed to protect children when Mayflower was reasonably able to do so, not whether Mayflower took *all* possible preventative steps that may have prevented the second incident.

Although measures suggested by the commissioner may have prevented the second incident, this possibility does not mean that Mayflower's actions or omissions necessarily constituted neglect. After the first incident, Mayflower was aware that a "touching game"

had occurred on its playground and that AV-1 and AV-2 were two of the participants in that incident. Mayflower was not aware of any inappropriate sexual behavior of any child prior to the first incident. And according to both the ALJ and the commissioner, Mayflower took "extensive measures to prevent recurrence of the [first] incident." Moreover, although Mayflower was unaware of any incident involving the yellow tube, it nonetheless instructed its staff to be sure to watch the yellow tube and the lilac bushes. Moreover, the department investigator did not note any deficiencies in Mayflower's policies and procedures and could not specifically identify what was deficient about the supervision. Despite having visited the playground on a number of occasions for licensing purposes, the department never raised the yellow tube as an area of concern or instructed Mayflower to get rid of it. Given the knowledge it had, we conclude that the evidence does not support the conclusion that Mayflower failed to provide care to or protect the children despite being reasonably able to provide such care or protection.

The commissioner also points to the fact that Mayflower implemented additional measures after the second incident as evidence that Mayflower did not adequately supervise the playground before the second incident. Specifically, after the second incident a staff member sits near the yellow tube to be able to see inside. But implementation of this measure does not mean that Mayflower should have anticipated that inappropriate touching would occur after the first incident despite its preventative measures, that such touching would occur in the yellow tube, and that the recurrence of this kind of incident would be prevented by stationing a staff member to constantly monitor the yellow tube.

Relying on the additional measures Mayflower took following the second incident as proof that Mayflower did not take all reasonable measures within its power, and as a basis for a maltreatment finding, transforms the neglect definition from failure to care for or protect a child "when reasonably able to do so" to "failure to take all steps that could have prevented the harm." Such a standard improperly requires Mayflower to have taken every possible step that could have prevented the harm, as determined with the benefit of hindsight, rather than considering whether Mayflower was reasonably able to prevent the harm but failed to do so, based on the facts known to Mayflower at the time.

The commissioner suggests that Mayflower should have suspected that AV-1 was the instigator of the inappropriate touching because Mayflower staff knew that AV-1 was in therapy. But the record indicates that when Olesen called AV-1's therapist, Olesen was told that the therapist had information about AV-1 and his family that she was unable to share. The commissioner also notes that, sometime between the first and second incidents, Mayflower learned from child-protection services that AV-1's mother was no longer able to pick him up. Although these facts indicate that Mayflower was aware that there were issues regarding AV-1's home life, they do not indicate that Mayflower was aware, should have been aware, or even should have suspected that AV-1 was likely to engage in an incident involving nonconsensual touching.

Finally, we note that (1) the commissioner found that Mayflower took extensive measures to prevent recurrence of the first incident; (2) Mayflower did not know or have reason to know which child had instigated the first incident; and (3) the commissioner, absent reliance on hindsight, failed to identify what act or omission was neglectful. We

therefore conclude that based on this record, the maltreatment determination was not supported by substantial evidence.

Reversed.