

Unlawful Use of Physical Restraint at Sununu Youth Services Center Manchester, NH

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EXECUTIVE SUMMARY

This report presents the results of an investigation the Disability Rights Center-NH (DRC) conducted into the physical restraint and injury of a child with disabilities held at the Sununu Youth Services Center (SYSC). DRC concluded that the actions of SYSC's staff violated several provisions of New Hampshire law regulating the use of restraint against children and constituted abuse under federal law.

In December 2016, two Sununu Youth Center Staff members restrained Zach,¹ a fourteen-year old with known emotional disabilities. Staff members grabbed Zach and pushed him to the floor. One staff member's full body weight landed on Zach's upper back. As a result, Zach's scapula (shoulder blade) was fractured. DRC did not learn of the injury until two months after it occurred, as SYSC staff did not comply with the legal requirement that they provide notice to DRC when restraint causes serious injury.

DRC investigated SYSC's use of restraint against Zach and, over the last year, examined the use of restraint against other children residing at the facility. During the investigation, DRC's access to records was significantly hindered by SYSC. DRC received the final records pertaining to the investigation of Zach's injury in December 2017 and still has not received important sets of records pertaining to SYSC's wider practices, several months after making the requests.

The investigation of the incident involving Zach revealed multiple violations of New Hampshire law. DRC determined that Zach's behavior did not pose a substantial and imminent risk of serious bodily harm, the legal threshold which must be met before restraint is permitted. Further, the restraint method used was found to violate the prohibition of restraint techniques that place weight on a child's back. DRC concluded that SYSC's use of restraint against Zach constituted abuse as defined by the federal Protection and Advocacy for Individuals with Mental Illness Act (PAIMI). Finally, with respect to Zach's restraint and resulting injury, DRC determined that SYSC failed to comply with New Hampshire law requiring it to provide timely notice of the incident to DRC.

The improper use of restraint upon Zach was not an isolated occurrence. DRC discovered multiple instances of physical restraint at SYSC in which children's behavior did not present a legally sufficient risk of serious bodily harm. SYSC records also indicate that the facility regularly uses prone restraint, a method that creates a risk of asphyxiation and other injury and is likely to violate New Hampshire law.

This report recommends that the state make meaningful changes to its policies and practices so that children held at SYSC are not subjected to unnecessary risk of harm. These include:

- Full compliance with all of the provisions of RSA 126-U, particularly those which prohibit restraint except when a child's behavior presents an imminent risk of serious bodily harm;
- Improved training of line and supervisory personnel to eliminate the unnecessary and unlawful use of restraint;

¹ "Zach" is a pseudonym assigned to protect this youth's confidentiality.

- Intensive monitoring of SYSC's use of restraint by the Department of Health and Human Services, either on its own or in cooperation with the Office of the Child Advocate, until SYSC demonstrates consistent compliance with RSA 126-U's requirements; and
- Compliance with federal law regarding DRC's access to records when DRC determines there is probable cause to suspect abuse and neglect.

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I. INTRODUCTION

On or about February 21, 2017, DRC received a complaint alleging that staff of the Sununu Youth Services Center (SYSC) physically abused a resident, Zach.² The reporter alleged that SYSC staff used excessive force and caused serious injury - a fractured scapula (shoulder blade) - and then delayed necessary medical care to Zach.

DRC investigated the incident, conducting interviews of Zach and SYSC staff, reviewing SYSC staff reports, and securing the opinion of New Hampshire's Chief Medical Examiner. DRC also reviewed the investigation file and report prepared by the Special Investigation Unit (SIU) of the New Hampshire Department of Health and Human Services' Division of Children, Youth and Families (DCYF) in response to a complaint filed with DCYF regarding this incident.³

DRC determined that SYSC staff subjected Zach, a child with emotional and behavioral disabilities, to abuse as defined in the PAIMI Act and regulations. The abuse finding was based on the improper use of restraint in violation of New Hampshire's law limiting the use of restraint and seclusion, RSA Chapter 126-U. DRC also concluded that SYSC violated that chapter's provisions requiring notification to DRC whenever serious injury is caused by restraint and accurate documentation of such incidents.

During the investigation, DRC received additional reports of restraint at SYSC. The details of the reports indicated that the unlawful restraint Zach experienced was not an isolated occurrence. DRC determined there was probable cause to suspect that SYSC has subjected, and is continuing to subject, children with mental illness to abuse, as defined by the PAIMI Act, through the improper and unlawful use of restraint.⁴ DRC notified SYSC's Director of this finding and the initiation of a broader investigation into allegations that SYSC's staff is engaging in the widespread improper and harmful use of restraint of children with disabilities who are housed at that facility.

This report focuses on DRC's investigation into the use of restraint which resulted in the fracture of Zach's scapula. Examples of separate incidents of restraint at SYSC are also included, as they indicate that SYSC regularly subjects children in its care to unjustified physical restraints, placing children at that facility at a continuing risk of physical and emotional harm.

² Names of the children have been changed throughout the report.

³ See Appendix A for a summary of DRC's investigation methodology. Due to statutory confidentiality requirements, the contents of the SIU Report are not included in this report.

⁴ Probable cause is defined as "reasonable grounds for belief that an individual with mental illness has been, or may be at significant risk of being subject to abuse or neglect." 42 C.F.R. §51.2.

II. BACKGROUND

A. SUNUNU YOUTH SERVICES CENTER AND POPULATION IT SERVES

The Sununu Youth Services Center (SYSC) is an architecturally secure residential placement for committed juveniles and detained youth, court-involved youth who have not yet been adjudicated. SYSC is administered by Juvenile Justice Services, part of New Hampshire's Department of Health and Human Services' Division of Children, Youth and Families. Following reforms adopted by the New Hampshire Legislature in 2017, the population at SYSC declined from an average census typically in the mid-60s to the current average population which is in the mid-40s.

New Hampshire's juvenile delinquency law requires that, for children found delinquent, the court order the "least restrictive" of an array of dispositions which the court finds most appropriate.⁵ Commitment and placement at SYSC is the most restrictive disposition for children.

Youth who have been committed to SYSC are usually held separately from detained youth. However, when committed or detained youth experience behavioral challenges, they may be transferred to the Crisis Services Unit (CSU). According to SYSC policy, the CSU is "the SYSC Unit to which a committed or detained youth is admitted when additional structure and therapeutic supports are required to achieve safety and behavioral stabilization."⁶ This policy further provides that the CSU may not be used as punishment for a youth's behavior. However, DRC's monitoring visits to the CSU throughout 2016 and 2017 revealed that youth are regularly transferred to the CSU for behaviors unrelated to personal safety. Residents transferred to the CSU are typically required to spend most of the day alone in their rooms. CSU residents are not permitted to have any personal items in their rooms other than one book and a bible. Nor are they provided full access to SYSC's regular recreation activities or clinical groups, even though nearly all youth transferred to the CSU have emotional disabilities. Access to SYSC's regular school may be restricted as well.

B. YOUTH IN THE JUVENILE JUSTICE SYSTEM

Youth with disabilities are disproportionately represented in the juvenile justice system, including in juvenile detention facilities. A 2015 Report issued by the National Disability Rights Network estimates that between 65 and 70% of children involved in the juvenile justice system have a diagnosed disability and that approximately 75% of children in the juvenile justice system have experienced traumatic victimization, placing them at risk for mental health disorders such as post-traumatic stress syndrome.⁷ One recent study found that more than 90% of detained youth experienced at least one traumatic

⁵ RSA 169-B:19.

⁶ SYSC Policy No. 2170.

⁷ Orphanages, Training Schools, Reform Schools and Now This? Recommendations to Prevent the Disproportionate Placement and Inadequate Treatment of Children with Disabilities in the Juvenile Justice System, National Disability Rights Network (2015), p.12, available at http://www.ndrn.org/images/Documents/Issues/Juvenile_Justice/NDRN_-_Juvenile_Justice_Report.pdf.

event.⁸ National studies have estimated that as many as three out of four youth in the juvenile justice system have been exposed to traumatic victimization and, of those, between 11 and 50% have Post Traumatic Stress Disorder (PTSD).⁹ These children may have been physically and/or sexually assaulted, threatened with weapons, witnessed violence in their homes or streets or experienced a traumatic loss such as the death of a parent or removal from a parent's home to foster care.¹⁰

Although New Hampshire does not report definitive numbers, available information suggests that the rate of emotional disabilities and trauma among children in New Hampshire's juvenile justice system mirrors national trends. For example, in 2008, Dr. Eric Vance, then medical director of New Hampshire's Juvenile Justice Services, part of the NH Department of Health and Human Services, estimated that 60-70% of the boys and 70-90% of the girls at SYSC have been physically and/or sexually abused and are dealing with PTSD.¹¹

C. PHYSICAL AND PSYCHOLOGICAL DANGERS OF RESTRAINT

Physical restraint, as referenced in this report, includes methods SYSC may use to restrict a child's ability to freely move his or her torso, head, arms or legs. This may take various forms including staff members using bodily force to bring a child down to the ground or a bed, or against a wall, and holding the child in place. It also includes the use of mechanical restraints, such as shackles.¹² New Hampshire law limits the circumstances in which restraint may be used to emergencies and prohibits the use of certain types of restraints known to be particularly dangerous.¹³

Physical restraint of children is dangerous and should be avoided whenever possible.¹⁴ Restraint places children and staff at risk of physical harm. Even if no physical injury results from a restraint, the

⁸ Abram, Teplin, *et al.*, *PTSD, Trauma, and Comorbid Psychiatric Disorders in Detained Youth*, OJJDP Bulletin, June 2013, available at <https://www.ojjdp.gov/pubs/239603.pdf>.

⁹ Ko, S. J., Ford, J. D., Kassam-Adams, N., Berkowitz, S. J., Wilson, C., Wong, M., ... & Layne, C. M. (2008). Creating trauma-informed systems: child welfare, education, first responders, health care, juvenile justice. *Professional Psychology: Research and Practice*, 39(4), 396.

¹⁰ Defending Childhood, Report of the Attorney General's National Task Force on Children Exposed to Violence (2012), p. 171, available at <https://justice.gov/defendingchildhood/cev-rpt-full.pdf>; Morris, K., and Morris, R., Disability and Juvenile Delinquency: Issues and Trends, 615 and 617 (*Disability & Society*, 21(6), 613-627) (2006).

¹¹ Minutes from June 23, 2008 meeting of the "Commission to Develop a Comprehensive State Mental Health Plan Corrections Committee."

¹² See RSA 126-U:IV for the full definition of "restraint" applicable to children in schools and facilities. See also, Section III.B *infra* for a description of New Hampshire's law restricting the use of restraint in schools and facilities that serve children.

¹³ *Id.*

¹⁴ U.S. Department of Education, *Restraint and Seclusion: Resource Document*, Washington D.C., 2012, available at <https://www2.ed.gov/policy/seclusion/restraints-and-seclusion-resources.pdf>.

experience of being restrained is traumatic and can have serious adverse psychological impacts.¹⁵ For children subjected to restraint, particularly those who have experienced prior physical or sexual abuse or trauma, the experience of being restrained may cause re-traumatization.¹⁶ Far from being a therapeutic practice, restraint is known to contribute to setbacks in a child’s response to treatment.¹⁷

Besides being dangerous, restraint has not been demonstrated to provide any therapeutic or educational benefit. According to the U.S. Department of Education, “[t]here is no evidence that using restraint . . . is effective in reducing the occurrence of the problem behaviors that frequently precipitate the use of such techniques.”¹⁸ Rather than assisting a child to calm down and gain control of his or her behavior, the use of restraint tends to escalate a child’s emotional state.¹⁹

D. DRC’S INVESTIGATIVE AUTHORITY AND HISTORY OF SYSC INVESTIGATIONS

The Disability Rights Center – NH (DRC) is an independent, private nonprofit organization, designated under federal law to protect and advocate for the rights of individuals with disabilities. As New Hampshire’s Protection and Advocacy System (P&A), DRC is mandated to operate seven protection and advocacy programs including Protection and Advocacy for Individuals with Mental Illness (PAIMI).²⁰

One of DRC’s core protection and advocacy activities is to investigate incidents of alleged abuse and neglect of individuals by the facilities that provide services to individuals with mental illness.²¹ Federal

¹⁵ Mohr, W., Ph.D., *et al.*, Adverse Effects Associated with Physical Restraint, 331 (Can J Psychiatry, Vol. 48, No 5) (June 2003), available at <http://journals.sagepub.com/doi/pdf/10.1177/070674370304800509>; United States General Accounting Office, “Extent of Risk from Restraint and Seclusion is Unknown” (1999), Testimony before the Committee on Finance, U.S. Senate. 26 Oct. 1999, available at <https://www.gao.gov/new.items/he00026t.pdf>.

¹⁶ Jennings, A., Ph.D. The Damaging Consequences of Violence and Trauma: Facts, Discussion Points, and Recommendations for the Behavioral Health System (2004), available at <https://www.theannainstitute.org/Damaging%20Consequences.pdf>.

¹⁷ U.S. GAO (1999) *Id.*

¹⁸ U.S. DOE (2012) *Id.*

¹⁹ Judith G. Storandt, Esq., Use of Force in Juvenile Correctional Facilities, 16 (National Disability Rights Network) (2006); and Smith & Bowan, The Restraint Spiral: Emergent Themes in Perceptions of the Physical Restraint of Juveniles, 77 (Child Welfare, Vol., 88,#3) (2009).

²⁰ The Protection and Advocacy for Mentally Ill Individuals Act of 1986 provides for the PAIMI program which is funded and overseen by The Center for Mental Health Services (CMHS) within the U.S. Department of Health and Human Services. See 42 U.S.C. § 10801 *et seq.* DRC also operates Protection and Advocacy for Persons with Developmental Disabilities (PADD), Protection and Advocacy for Individual Rights (PAIR), Protection and Advocacy for Assistive Technology (PAAT), Protection and Advocacy for Beneficiaries of Social Security (PABSS), Protection and Advocacy for Persons with Traumatic Brain Injury (PATBI), and Protection and Advocacy for Voting Access (PAVA).

²¹ 42 U.S.C. §10805(a)(1)(A).

law confers broad authority upon the DRC to conduct interviews of residents and employees and to gather and review medical and other necessary records to investigate alleged abuse or neglect.²²

Since at least 2008, DRC has received and investigated reports alleging abuse and neglect of youth at SYSC, including staff using excessive force, unnecessarily restraining children and subjecting residents to prolonged isolation. DRC has repeatedly brought its concerns about mistreatment of children at SYSC to the attention of the New Hampshire Department of Health and Human Services, including officials responsible for SYSC's operations.

In 2009, DRC issued a public report substantiating an allegation of abuse and neglect committed by two SYSC employees against a fourteen-year old SYSC resident with emotional disabilities. Following an extensive investigation of alleged abuse and neglect, DRC determined that SYSC staff had used unnecessary and excessive force against this boy, including subjecting him to a take-down restraint in an extremely small space, dragging him face-down across the floor and holding him in a prone restraint for a prolonged period of time.²³ Further, DRC found that the youth's behavior leading to staff's use of restraint did not justify staff's actions and that those actions were unnecessary, excessive and carried out in a manner that was abusive and dangerous.

Following the issuance of this report, DRC undertook a broad investigation into the use of force and restraint at SYSC. DRC's investigation revealed a pervasive pattern of inappropriate restraints and excessive use of force by SYSC against the children housed there.²⁴

The recommendations made in DRC's 2010 report of its broader investigation into the use of restraint include:

- SYSC must ensure youth housed at SYSC are not subjected to excessive, unjustified or unnecessary restraints, in compliance with RSA 126-U;
- SYSC must provide regular reports on the use of restraint to monitor progress in reducing its use, and improve staff training to prevent power struggles with youth which often lead to the unnecessary use of force and physical restraint; and
- New Hampshire's Juvenile Justice Services and Department of Health and Human Services must promulgate rules under RSA 541-A that "clearly establish procedures for the investigation of suspected abuse and neglect of children in institutional settings, pursuant to RSA 169-C:37 and RSA 169-C:3-a(III)."

²² 42 U.S.C. §10805(a)(1)-(4), 42 C.F.R. §§51.41-51.42.

²³ Cohen, R. and Whitley, R., *Initial Investigation Report, Findings & Recommendations on Allegation of Use-of-Force and Mechanical Restraint Against Detained Youth at the John H. Sununu Youth Services Center on June 9, 2008 (January 2009)*, available at <http://www.drcnh.org/SYSCReport.pdf>.

²⁴ Cohen, R. and Whitley, R., *Investigation Report, Findings & Recommendations, The Use of Force and Restraint and Adequacy of Mental Health Care at the John H Sununu Youth Services Center (October 5, 2010)*, available at <http://www.drcnh.org/SYSCReport2.pdf>.

These recommendations have not been implemented.

III. GOVERNING LAWS/STANDARDS

A. ABUSE UNDER THE PAIMI ACT

In relevant part, the PAIMI Act defines “abuse” as “any act or failure to act by an employee of a facility rendering care or treatment which was performed, or which was failed to be performed, knowingly, recklessly, or intentionally, and which caused, or may have caused, injury or death to an individual with mental illness, and includes acts such as: . . . the striking of an individual with mental illness; the use of excessive force when placing a[n] individual with mental illness in bodily restraints; and the use of bodily or chemical restraints on an individual with mental illness which is not in compliance with federal and state laws and regulations”²⁵ (emphasis added).

B. NH’S LAW LIMITING THE USE OF RESTRAINT AND SECLUSION – RSA 126-U

Following the issuance of the first of the two reports by DRC discussed above, the New Hampshire legislature responded to concerns about the dangerous use of restraint and enacted RSA 126-U, a law limiting the use of restraint of children by facilities and schools.²⁶

This statute is intended to protect children from the dangers associated with the use of restraint. It limits the circumstances under which schools and facilities may use restraint in response to a child’s behavior to emergency situations. Under RSA 126-U:5, I, physical restraint may only be used “to ensure the immediate physical safety of persons when there is a substantial and imminent risk of serious bodily harm to the child or others.” In addition, only “trained personnel” are permitted to use restraint and only “when all other interventions have failed or have been deemed inappropriate.”²⁷ Dangerous restraint techniques, including physical restraint that places pressure or weight on a child’s back, are prohibited.²⁸ Further, this statute prohibits the use of restraint as punishment for a child’s behavior.²⁹

In addition to governing the circumstances under which restraint may be used and qualifications of personnel who may implement restraints, New Hampshire law requires schools and facilities to promptly notify parents/guardians, both orally and in writing, whenever their children are restrained. See RSA 126-U:7, I (requiring facilities like SYSC to provide verbal notice no later than the end of the business day) and RSA 126-U:7, III (requiring facilities to send a comprehensive written report concerning the use of restraint or seclusion). Finally, facilities and schools are required to notify the

²⁵ 42 U.S.C. §10802(1).

²⁶ In 2014, RSA 126-U was amended to restrict the use of seclusion as well as restraint, clarify the definition of restraint and enhance reporting requirements of incidents involving the use of physical force against a child.

²⁷ *Id.*

²⁸ RSA 126-U:4,I.

²⁹ RSA 126-U:5,II.

Commissioner of the Department of Health and Human Services, the Attorney General and Disability Rights Center – NH, as the state’s protection and advocacy agency for individuals with disabilities, of incidents of restraint or seclusion that result in serious injury to, or death of, a child in a facility.³⁰ Serious injury is defined as “any harm to the body which requires hospitalization or results in the fracture of any bone.”³¹

C. SYSC’S POLICIES PERTAINING TO THE USE OF RESTRAINT

SYSC has adopted written policies in line with New Hampshire’s law restricting the use of restraint. The policies express a commitment to maintaining a “safe and therapeutic environment” for children at the facility. SYSC’s policies permit the use of physical restraint but only when a youth’s behavior poses a substantial and imminent risk of serious bodily harm. This limitation is in accord with New Hampshire law.

For the most part, SYSC’s policy concerning the use of restraint³² mirrors the requirements in RSA 126-U. Some notable provisions are as follows. SYSC staff are required to secure written approval from a supervisor before using restraint, “when circumstances permit.” Restraint is to be limited to “the least amount of force necessary to ensure the safety of the youth and/or others.” The policy prohibits the use of dangerous restraint techniques including prohibiting staff from leaving youth in a prone position “due to the possibility of positional asphyxia.” The policy also requires SYSC’s clinical staff to assess the well-being of a child subjected to a restraint within 24 hours.

D. SYSC’S OBLIGATION TO PROVIDE RECORDS PROMPTLY

The PAIMI Act authorizes DRC, as New Hampshire’s Protection and Advocacy system, to investigate incidents of suspected abuse or neglect of individuals with mental illness.³³ Once DRC commences an investigation, it is entitled to access all records of the individual or individuals subjected to suspected abuse or neglect.³⁴ Facilities such as SYSC must provide DRC access to requested records “promptly.”³⁵

IV. SUMMARY OF THE INCIDENT AND DRC’S INVESTIGATION

A. BACKGROUND

Zach was 14 years old at the time of the incident described in this report. He has been diagnosed with mental illnesses including severe anxiety and Post Traumatic Stress Disorder (PTSD). Zach has an Individualized Education Plan (IEP) due to his emotional disabilities and has been prescribed medication

³⁰ RSA 126-U:10, I.

³¹ RSA 126-U:1, VI.

³² Policy No. 2083, Restraint.

³³ 42 U.S.C. § 10801.

³⁴ 42 U.S.C. § 10805.

³⁵ 42 C.F.R. § 51.41(a).

and therapy for ADHD and anxiety. Zach's was "detained" at SYSC, a placement which was intended to be temporary while awaiting an opening at a community-based residential program. At the time of the incident, Zach had been at SYSC for two weeks. SYSC did not assign an individual clinician to work with Zach as SYSC does not generally provide individual clinicians for detained youth.

On December 29, 2016, as a consequence for disobeying an order to go to his room, Zach was moved to the Crisis Services Unit (CSU), where he was supposed to receive additional structure and therapeutic supports. He was put into a room alone and told to stay there.

Zach was upset about being transferred to the CSU and being forced to stay alone in his room. Confinement in the CSU meant he would have no personal possessions other than one book and a bible. His telephone privileges would be cut in half and he would likely be prohibited from attending his regular school or recreational programs. The door to Zach's room was not locked, but leaving his room without permission would put Zach at risk of further consequences.

B. THE INCIDENT AND INJURY

Video footage of the CSU beginning approximately 15 minutes before the incident under investigation shows at least two instances in which Zach opened the door to his room and stood just outside his room, for a minute or two, while holding the door open. There were two youth counselors on the unit at this time – Shane Arsenault and Richard Gilibert. Due to the lack of sound and quality of the video display, it is difficult to tell whether Zach and staff spoke during these instances. Zach backed into his room each time and closed the door without any physical interaction with staff.

Approximately 3 minutes before the incident, Supervisor Joel White entered the CSU. Zach liked Supervisor White and wanted to talk with him. Zach knocked on his door and asked to leave his room. Not hearing a response from staff, Zach opened the door to his room, and repeated his request for permission to leave his room. Staff told Zach to get back into his room, but Zach continued to hold the door open and attempt to speak with Supervisor White.³⁶

All three staff (Gilibert, Arsenault and White) approached Zach almost immediately after he opened the door. Gilibert pushed Zach back into his room, closed the door, and held it shut with one foot and two hands. Zach told DRC's investigators that he responded by shouting "you can't push kids," or words to that effect. A report of the incident indicates that Zach shouted threatening expletives at staff.³⁷ It appears that Zach was attempting to push the door open as Gilibert held it closed.

³⁶ The video recording of the incident does not have sound. This paragraph reflects the conversation as reported by Zach.

³⁷ As the video recording of the incident does not have sound, DRC is unable to determine what Zach said to SYSC staff. However, it should be noted that Zach did not pose a danger to staff or other residents because staff members were holding the door closed. If staff were not able to continue holding the door shut, they could have locked the door to the room.

Gilbert continued holding the door closed in this manner for approximately seven seconds, at which time he opened the door to Zach's room, pushed him further inside and rushed inside Zach's room, where Gilbert restrained Zach.³⁸ According to Zach, Gilbert entered his room, posturing with his chest out. Zach recalled putting his hand out defensively, which made contact with Gilbert's chest as Gilbert continued to come towards him. Gilbert then threw Zach to the ground, put his knee on Zach's back to hold him down, put his hand on Zach's head, and pressed his face against the ground.

After about ten seconds, Gilbert left Zach's room. Zach attempted to hold the door open as Gilbert pushed the door closed and then held it closed, using one foot and his hands. Zach kicked and banged on the door of his room, attempting to open it, while Gilbert held the door closed. Arsenault joined Gilbert at the door.

Gilbert opened the door, immediately grabbed Zach's left arm and pulled him out of the room. Arsenault quickly grabbed Zach's right arm, holding it out to the side. Zach was then pushed to the floor, where he landed in a prone, face-down position.

As indicated in the Chief Medical Examiner's report concerning her review of the restraint video, "it appears that the full body weight of Gilbert lands on Zach's upper back while Zach's left arm is being held out to the side and behind him."³⁹

Zach was held in the prone position for approximately ten seconds, after which Arsenault and Gilbert pulled up on Zach's arms, then being held behind his back, and lifted him to his feet. They then escorted Zach, continuing to hold both of Zach's arms behind his back, to CSU Room 120, a room with a rubber bed and video camera, and placed him on the bed.

Zach did not resist staff's use of force during the takedown or while he was being restrained on the floor. He did, however, experience significant pain as a result of this takedown and restraint. A resident DRC interviewed recalled that when Zach went down to the floor, he was crying and yelled, "stop, stop, my arm," or words to that effect.⁴⁰

C. SYSC'S RESPONSE TO THE INJURY

After the incident, Zach held his shoulder and cried over the course of an hour and a half. He requested medical attention. A nurse gave him ice and ibuprofen and scheduled him to see the doctor the next day. Zach was not offered an opportunity to meet with a mental health clinician following this incident, despite his admission to the unit intended for crisis services and having just experienced the trauma of a violent restraint.

³⁸ Due to a lack of recording equipment, there is no video footage inside Zach's room. A review of the incident reports, State Police Report and interviews indicate that Gilbert restrained Zach on the floor of his room for a brief time.

³⁹ See Report of Chief Medical Examiner dated September 13, 2017, p. 2, attached hereto as Appendix B.

⁴⁰ There is no audio-recording of this incident. DRC, therefore, cannot confirm reports of what Zach said.

Zach saw a doctor at SYSC the next day. The doctor told Zach the shoulder was not dislocated, put him on a sports restriction, prescribed ibuprofen and ice and requested that he have an x-ray at Catholic Medical Center.

SYSC's medical contact log indicates that the medical department called Zach's parent to notify her of the need for a shoulder x-ray at 9:05 a.m. on December 30th.

SYSC's unit staff did not take Zach's complaints about his shoulder injury seriously. Zach's injury made it difficult, and more time consuming, to dress, undress and shower. Rather than acknowledge the impact of Zach's injury on his ability to care for himself, SYSC's unit staff criticized him for taking too long to shower. Zach attempted to fashion a sling out of his clothing. Staff responded by threatening to take away Zach's clothes and replace them with strong clothes.⁴¹

Further, SYSC's unit staff provided instructions that hurt Zach and could have impeded his recovery. Staff told Zach to do exercises including lifting his arm, but this was painful. Later, an orthopedist told Zach that was bad advice.

A nursing progress note dated December 31, 2016 provides that Zach "stated he is unable to raise his left arm above his head or hold his left arm up."

The extent of Zach's injury was revealed on January 3rd, five days after he sustained the injury. On that day, an x-ray showed a fracture to Zach's left scapula. That same day, Zach was transported to the circuit court for a hearing. The court issued an order immediately releasing Zach from SYSC and placing him at a shelter care facility.

D. NOTIFICATION

MID-JANUARY 2017

On or about January 11, 2017, Zach's parent received a document entitled "RSA 126-U Reportable Seclusion/Restraint Notification Form" which described this incident.⁴² The document indicated the following reasons for using restraint: "Defend self or third person from imminent danger, Escort, and Remove a disruptive youth who is unwilling to leave an area voluntarily." Although the video recording shows no attempted assault, this report states that "Zach attempted to hit a supporting staff member." The report also falsely states that Zach was lying on his back during the restraint. The video recording clearly shows that Zach was in a dangerous face-down position.

FEBRUARY 2017

In mid-February 2017, DRC received a complaint alleging that an SYSC resident's shoulder blade had been fractured during a restraint at SYSC. A few days later, during an informal conversation with DRC's

⁴¹ Strong clothes are designed so that they cannot be used for self-harm.

⁴² A letter from Director Serafin to Zach's parent indicates that the letter and report of this incident were mailed to the parent on January 6, 2017.

Policy Director, Sununu Center Director Brady Serafin disclosed that a child's bone was fractured during a restraint in 2016.

When DRC's Policy Director reminded him of his responsibility to report such serious injuries to DRC under New Hampshire law, Director Serafin claimed unfamiliarity with this requirement. DRC's Policy Director confirmed his request for the required information pertaining to this incident in an email to Director Serafin the same day. Despite DRC's oral and written communication to Director Serafin, SYSC's violation of the reporting law continued.

APRIL 2017

Following DRC's repeated requests for all required information pertaining to this incident, DRC did not receive all the information required by New Hampshire law until April 7, 2017 --- more than 3 months after Zach was restrained and sustained a broken bone.

AUGUST - DECEMBER 2017

Over the course of several months, DRC repeatedly requested and was told it would receive the DCYF Special Investigation Unit's report about the incident. DRC did not receive the report until mid-December 2017, despite its completion on or about October 12, 2017 and affirmance by the New Hampshire Department of Justice on October 16, 2017.

E. IMPEDIMENTS TO DRC'S INVESTIGATION

Throughout this investigation, SYSC has delayed their reporting and disclosure obligations under state and federal law.

Because SYSC failed to timely comply with its reporting obligations under the New Hampshire restraint statute, the beginning of DRC's investigation was delayed until months after the incident occurred. Such delay is inconsistent with the enforcement scheme established by the New Hampshire legislature when it enacted RSA 126-U. Delays in investigations such as this significantly increase the likelihood of diminished memories, loss of documentary and physical evidence, and inability to locate witnesses. Delay also increases the opportunity for witnesses to consult with each other to coordinate their versions of events. This is a particular danger when witnesses' own conduct may have violated the law or institutional standards, such as in this investigation. These consequences undermine the investigative and protective functions of the DRC, and can result in the persistence of unsafe institutional conditions for vulnerable children with disabilities.

An unredacted draft of portions of this report, including DRC's factual findings and conclusions, was provided to SYSC Director Brady Serafin through his legal counsel, on April 16, 2018. Director Serafin was asked to correct any factual inaccuracies by April 20, 2018. On April 20, Director Serafin, through his legal counsel, indicated that he could not review the report within the 5 days requested and asked for a two-week extension, until May 4, 2018, indicating that he had "identified numerous factual inaccuracies, critical omissions and legal issues." DRC delayed the publication of the report for an additional two weeks as requested. As of the publication of this report, on May 8, 2018, DRC has not received any

correspondence from Director Serafin or his legal counsel with evidence of additional factual inaccuracies, critical omissions or legal issues.

SYSC's failure to promptly provide records is ongoing. In the fall of 2017, DRC requested additional records under its federal investigative authority⁴³ including documents and video recordings relating to the restraint of a number of children who were housed in the CSU from March to May 2017. On May 3, 2018, DRC was informed that SYSC possessed, but had not provided, documents that DRC had requested on November 6, 2017. Learning that the records did exist, but had not been shared, prompted DRC to revise its report significantly.

F. EXPERT REVIEW - DR. JENNIE DUVAL

DRC retained Dr. Jennie Duval, New Hampshire's Chief Medical Examiner, to review records pertaining to the incident and injury and to render an opinion as to the probability that the injury Zach suffered was caused by SYSC staff's physical interaction with Zach. Dr. Duval reviewed medical records from Cheshire Medical Center, including digital radiographs, medical records, incident reports from SYSC, along with video recordings of the incident. The opinion issued by Dr. Duval is attached as Appendix B.

Dr. Duval concluded, "[Zach] sustained a fracture of his left scapula when he was physically restrained by staff members at the SYSC on 12/29/2016." Further, Dr. Duval concluded this injury "most likely occurred during the takedown procedure . . . when staff member Richard Gil[i]bert landed on [Zach's] upper back while holding [Zach's] left arm away from his body."⁴⁴ According to Dr. Duval, fractures to the scapula are rare because of the scapula's "position, mobility and encasement in muscle tissue."⁴⁵ Most frequently, when the scapula is fractured, it is due to "high-energy trauma as may occur with motor vehicle accidents."⁴⁶

In her report, Dr. Duval provides a detailed description of the videos she reviewed. It is notable that, contrary to the description of the event provided in SYSC's incident reports, Dr. Duval did not observe any attempt on Zach's part to hit a staff member. Rather, Dr. Duval observed, "Gil[i]bert opens the door and grabs [Zach's] left arm pulling him into the hallway as Arsenault grabs [Zach's] right arm." Further, Dr. Duval observed, "[Zach] is then pushed to the floor landing in a prone position. In the process it appears that the full body weight of Gil[i]bert lands on [Zach's] left upper back while [Zach's] left arm is being held out to the side and behind him."⁴⁷

V. CONCLUSIONS

⁴³ See 42 U.S.C. § 10805(a)(1)(A); 42 C.F.R. § 51.41(a).

⁴⁴ Opinion, p. 2.

⁴⁵ *Id.*

⁴⁶ *Id.*

⁴⁷ Opinion, p. 1.

The use of physical restraint against Zach was excessive and caused Zach to suffer a fractured scapula. Further, the restraint was improper and violated the protections provided in RSA 126-U, New Hampshire's law limiting the use of restraint.

In violating RSA 126-U, the conduct of SYSC's staff constituted abuse as defined by the PAIMI Act.

Additionally, with respect to the use of restraint against Zach and resulting injury, SYSC violated RSA 126-U:10's reporting requirements by failing to provide DRC with timely notice of the restraint.

Finally, the improper and unlawful use of restraint was not an isolated occurrence, as evidenced by a review of a sample of additional restraints from January to September 2017. Rather, SYSC routinely fails to comply with RSA 126-U's protections and limitations on the use of restraint, thereby placing children with disabilities at risk of physical and emotional harm.

A. THE CONDUCT OF SYSC'S STAFF CONSTITUTED ABUSE AS DEFINED BY THE PAIMI ACT

1. SYSC staff's use of restraint was improper and violated the protections provided in RSA 126-U, New Hampshire's law limiting the use of restraint.
2. Youth Counselor Gilibert's use of physical restraint against Zach was dangerous, excessive and caused Zach to suffer a fractured scapula.

SYSC staff committed abuse as defined in the PAIMI Act as the restraint they performed, which resulted in Zach's injury, was not in compliance with the limitations and protections provided in RSA 126-U. Under the PAIMI Act, "abuse" includes "the use of bodily . . . restraints on a[n] individual with mental illness which is not in compliance with . . . state laws."⁴⁸ The use of restraint against Zach did not comply with New Hampshire law because Zach's behavior did not pose a substantial and imminent risk of serious bodily harm to himself or others as required by RSA 126-U:5, I. The restraint notification report completed by SYSC staff lists three reasons for restraining Zach - to defend themselves or third person from imminent danger, escort and to remove a disruptive youth who is unwilling to leave an area voluntarily.⁴⁹ Of these reasons, only one -- to defend themselves or third person from imminent danger -- might justify the use of restraint under RSA 126-U.

The report's narrative of the events leading to the restraint that caused the fracture indicates that after SYSC staff used a "MACH 1" escort⁵⁰ to move Zach to a different room, Zach "attempted to hit a supporting staff member." However, the video recording of this incident does not show any attempt by

⁴⁸ 42 U.S.C. §10802(1).

⁴⁹ SYSC attempted to characterize the effort to move Zach to room 120 as an "escort," which is not considered a restraint under New Hampshire law and is, therefore, permissible. However, the video of the incident does not portray an escort. Rather, the video shows staff forcibly removing Zach from the room and immediately taking him to the ground. Further, contrary to staff's claim that the restraint was in response to an attempted assault, there is no indication in the video of any attempt on Zach's part to assault staff. Nor does the video indicate that Zach's behavior preceding the takedown and restraint posed a substantial and imminent risk of serious bodily harm.

⁵⁰ Mechanical Advantage Control Holds (M.A.C.H.) are physical control methods employed by SYSC to manage youth in their care.

Zach to strike SYSC staff. Rather, the video recording shows staff entering Zach's room, forcibly removing him and bringing him down to a prone, face-down position on the ground. Further, as DRC and the Medical Examiner noted, Gilbert's full weight was on Zach's back. This method of restraint is dangerous and violates RSA 126-U:4, I (b) which prohibits the use of restraints that place pressure or weight on a child's back.

DRC's review of a sample of restraints between January and September of 2017 revealed multiple instances in which SYSC residents were restrained even though they did not pose a substantial and imminent risk of serious bodily harm, in violation of RSA 126-U:5. For example, in April 2017, SYSC staff restrained Chris, a 14-year old with multiple disabilities including anxiety, bi-polar disorder and fetal alcohol syndrome, for taking a staff member's radio. The restraint occurred after Chris surrendered, and staff had secured, the radio. After this restraint, staff locked Chris alone in a stripped-down room, where he remained for about an hour. A video recording taken inside the room shows Chris purposely and repeatedly hitting himself in the face, bleeding and then using his blood to write on the walls of the room. SYSC staff took no action to prevent Chris from this self-injurious behavior. SYSC staff's report lists the following reasons for restraining Chris: "remove a disruptive youth who is unwilling to leave an area voluntarily" and "Other – Chris took a radio from staff & refused to return it." Neither of these reasons justify the use of restraint under RSA 126-U:5. Nor do the report narratives or a review of the video recording of this incident indicate that restraint was justified under New Hampshire law.

Also in April 2017, SYSC restrained Rachel, a 15-year old girl with diagnosed mental illness, for refusing to go to her room to cool off from an upsetting phone call with her parent. SYSC staff's reported justification for restraining Rachel was "remove a disruptive youth who is unwilling to leave an area voluntarily." There was no indication in the records DRC reviewed or video recording of this incident that Rachel posed an imminent risk of serious bodily harm as required by New Hampshire law to justify the use of restraint.

On August 28, 2017, SYSC staff restrained Nick for attempting to leave a room on the CSU to which he had been confined for a prolonged period of time. Nick is a small, 13-year old boy who has been diagnosed with serious mental illness and determined eligible for special education. SYSC staff's reports indicate that, after entering the room on the CSU, Nick "decided to engage in self-harmful behaviors like hiding under the desk and attempting to tie a shirt around his neck." In response, SYSC removed the shirt from Nick's neck and escorted him to Room 120, a room with a camera located on the CSU. SYSC reports indicate that Nick "continued to engage in self-harmful behavior" including stating he wanted to kill himself and attempting to leave the room without permission. In response, SYSC staff locked Nick into the room for approximately one hour and fifteen minutes. When staff unlocked the door, Nick again attempted to leave the room without permission. Staff then took him down to the floor and held him in a prone restraint. There is no indication in staff reports or video that Nick's behavior presented an immediate risk of serious bodily injury, as required to justify the use of restraint. Rather, staff's stated reason for this restraint was "remove a disruptive youth who is unwilling to leave an area voluntarily."

Additionally, DRC's review revealed that SYSC routinely uses prone, face-down restraint, a dangerous technique, in violation of both New Hampshire law and its own policy prohibiting the use of certain

dangerous restraint techniques including holding youth in a prone position.⁵¹ In each of the instances described above, SYSC staff held youth in the prone position.

⁵¹ In relevant part, SYSC Policy No. 2083, para. VII provides, “Youth in restraint **shall not** be left in a prone position due to the possibility of positional asphyxia. ‘Positional Asphyxia’ means when the position of a person’s body cuts off or interferes with their breathing that leads to hypoxia, an inadequate amount of oxygen to meet the body’s demand.” Policy No. 2083, VII,F. (emphasis in original).

B. SYSC FAILED TO COMPLY WITH RSA 126-U REPORTING REQUIREMENTS

1. FAILURE TO PROVIDE DRC WITH TIMELY NOTICE OF THE RESTRAINT

SYSC's Director, Brady Serafin, did not provide timely notification to DRC of the incident under investigation as required by New Hampshire law. RSA 126-U:10 provides, "[i]n cases involving serious injury or death to a child subject to restraint or seclusion in a facility, the facility shall ... notify the commissioner of the department of health and human services, the attorney general, and the state's federally-designated protection and advocacy agency for individuals with disabilities." The DRC is the state's protection and advocacy agency. SYSC is a facility regulated by this statute and "serious injury" includes bone fractures. RSA 126-U:1 III (a) and VI. SYSC therefore had a duty to report the injury to DRC but failed to do so until months later, when prompted repeatedly by DRC.

2. FAILURE TO ACCURATELY REPORT INFORMATION

RSA 126-U:7, II requires facility employees to provide particular written documentation any time a child in their care is restrained. The information employees are required to report includes, but is not limited to, descriptions of the child's behavior preceding the restraint, justification for the use of restraint, efforts to avoid the use of restraint, the type of restraint used and a description of any injuries sustained by the child or employees. One purpose for this record-keeping requirement is to ensure compliance with the law. Another is to make sure sufficient information is available for facilities to analyze the use of restraint and avoid the use of restraint in the future.

SYSC's written reports regarding the incident under investigation are not accurate. The RSA 126-U Reportable Seclusion/Restraint Notification Form (126-U Report) regarding this incident lists several reasons for restraining Zach, only one of which might meet the risk threshold to justify the use of restraint under RSA 126-U:5 - "defend self or third person from imminent danger."⁵² In staff's description of the incident, the staff member who completed this report wrote, Zach "attempted to hit" a member of SYSC's staff. A staff witness report completed by Arsenault states, "when Gilibert opened the door to [Zach]'s room he gained control of his left arm. Once in control of his left arm . . . [Zach] with a closed fist, brought back and swung forward his right fist in [Arsenault's] direction." However, careful review of the video recording of the incident demonstrates that SYSC staff did not accurately report their justification for the restraint. The video recording that captured the incident does not show Zach attempting to hit staff.⁵³ Rather, as indicated above, the video shows Gilibert open Zach's door, immediately grab his arm and take him down to the ground. Further, Arsenault's report fails to mention that, while taking Zach down to the floor, Gilibert's full weight landed on top of Zach. Finally, although

⁵² The other reasons staff list for restraining Zach are "Escort" and "Remove a disruptive youth who is unwilling to leave an area voluntarily." It is notable that staff did not identify "substantial and imminent risk of serious bodily harm to self or others," the only permissible justification to restrain a child in a facility under New Hampshire law, as a reason for this use of restraint.

⁵³ Neither the State Police, Chief Medical Examiner nor DRC's investigators who viewed the video recording of the incident observed Zach attempt to strike staff prior to the restraint.

the video of this incident clearly shows staff bringing Zach down to, and holding him in, a prone, face-down position, SYSC staff members who completed the RSA 126-U Restraint Notification Form indicated that Zach was lying on his back during the restraint.

VI. RECOMMENDATIONS

The restraint practices at the SYSC continue to be unnecessarily dangerous to children and in violation of state and federal law. Immediate changes to those practices are needed to protect the safety of children held at SYSC and to bring the practices there into compliance with the law. DRC recommends that the following be implemented as soon as possible:

A. Compliance with New Hampshire law:

1. As required by RSA 126-U:5, the use of restraint at SYSC should be limited to situations in which its use is necessary to “ensure the immediate physical safety of persons when there is a substantial and imminent risk of serious bodily harm to the child or others.”
2. The SYSC must fully and accurately comply with the notice provisions of RSA 126-U:7 and RSA 126-U:10. Notice of incidents of restraint involving serious injury or death to a child should be provided to the DRC and other required agencies no later than seven business days after such incidents and should include all information required by RSA 126-U:7,II. Parental notices required by the statute must comply with the content requirements of RSA 126-U:7.

B. Monitoring and reducing the use of restraint:

1. The SYSC should track and fully document the use of restraint at the facility. Staff involved in the use of restraint should be equipped with video cameras with sound recording capability to record all restraint incidents.
2. Staff members involved in restraint incidents should be required to promptly debrief each incident with supervisory and clinical staff. An explicit objective of the debriefing process should be the development of strategies to avoid the use of restraint in the future when possible.
3. The use of restraint by staff members should be regularly and frequently reviewed by SYSC leadership. When individual incidents indicate that personnel actions or additional training is needed to ensure the safety of SYSC’s residents, such action should be taken without delay.
4. The Department of Health and Human Services, either on its own or in cooperation with the Office of the Child Advocate, should conduct intensive monitoring of SYSC’s use of restraint until SYSC demonstrates consistent and full compliance with RSA 126-U’s requirements.

C. Training:

1. It is imperative that SYSC provide training in the safe use of physical restraint to all staff who work directly with children. Such training should emphasize the legal restrictions on the use of restraint in New Hampshire, limitations on dangerous restraint techniques such as were

discovered in this investigation, and the necessity of timely and accurate documentation of restraint incidents.

2. Staff at SYSC should also receive training, at least annually, on the use of positive behavior strategies which have been demonstrated to avoid the use of restraint.

D. Reporting:

SYSC must provide complete records to Disability Rights Center in a timely manner, as required by federal law.

APPENDIX A: SUMMARY OF DRC'S INVESTIGATION METHODOLOGY

DRC conducted site visits at SYSC and interviewed:

1. Zach.
2. Zach's Mother.
3. A resident who witnessed Zach's restraint which is the subject of this investigation as well as several of SYSC's current and former residents who had experienced or witnessed restraints at SYSC. (The names of the youth DRC interviewed are confidential.)
4. SYSC Director Brady Serafin.
5. SYSC Supervisor Joel White.
6. Dr. Jennie Duval, Chief Medical Examiner for the State of New Hampshire.
7. DRC attempted to interview the two SYSC staff members who were directly involved in Zach's restraint which is the subject of this investigation, Richard Gilibert and Shane Arsenault, but both individuals declined to discuss the incident.

DRC reviewed records and documents regarding the incident, the injury Zach suffered, medical diagnosis and treatment following the incident, including:

A. The following records and documents created and/or maintained by SYSC:

- Reports created by SYSC Staff members pertaining to the December 29, 2016 incident: RSA 126-U Reportable Seclusion/Restraint Notification Form, SYSC Major Incident Report, a Staff Witness Report, Safety Plan, medical records including Physician's Order Sheet, progress notes and nursing notes, created by members of SYSC's medical staff.
- Descriptions of the Mechanical Advantage Control Holds (M.A.C.H.), referenced in the above reports.
- Video recordings of the incident captured by SYSC's video monitoring system.
- Incident/Arrest Report completed by the New Hampshire State Police Report.
- Crisis Service Unit Figuring Out the Problem Worksheet, completed by Zach on or about December 31, 2016.
- Reports created by SYSC Staff members pertaining to an incident that occurred on December 28, 2016, on the H-Detained Unit and which resulted in Zach being placed in seclusion, placed on CSU status and then transported to CSU.
- SYSC Policies.

B. Medical records pertaining to the injury that DRC obtained from Catholic Medical Center, where the fracture was initially diagnosed.

C. Medical records, including x-ray images, DRC obtained from Cheshire Medical Center, which provided follow-up imaging and care.

D. Report of a Special Investigation of the incident conducted by New Hampshire's Division for Children, Youth and Families.⁵⁴

⁵⁴ Due to statutory confidentiality requirements, the contents of the SIU Report are not included in this report.

E. The Special Investigative Unit's investigative file.⁵⁵

F. Opinion of Dr. Jennie Duval, Chief Medical Examiner for the State of New Hampshire.

In addition, during the past several months, DRC reviewed a sample of incidents involving the use of restraint against SYSC residents who had been admitted to the CSU, the unit where Zach was injured. The incidents DRC reviewed occurred between January and September 2017. DRC obtained and reviewed SYSC records pertaining to each of the youth involved in these incidents, including incident and witness reports. In some cases, DRC was able to obtain and review video recordings of these incidents.

⁵⁵ Due to statutory confidentiality requirements, the contents of the SIU file are not included in this report.

ATTORNEY GENERAL
DEPARTMENT OF JUSTICE

OFFICE OF THE CHIEF MEDICAL EXAMINER

GORDON J. MACDONALD
ATTORNEY GENERAL



ANN M. RICE
DEPUTY ATTORNEY GENERAL

October 9, 2017

Disability Rights Center – NH
64 N. Main St., Suite 2
Concord, NH 03301-4913

ATT: Karen L. Rosenberg, Senior Staff Attorney

RE: SYSC injury investigation

Dear Attorney Rosenberg:

As requested, I am providing my opinion regarding an injury (left distal scapula fracture) sustained by 14 year old ██████ while residing at the Sununu Youth Services Center (SYSC). The following is based on my review of all the information provided to me by your office (i.e. medical records from the Cheshire Medical Center including digital radiographs, medical records and incident reports from the SYSC, and video recordings of the incident), my training and experience in forensic pathology and review of the relevant medical literature.

According to incident reports and video recordings from the SYSC, ██████ was physically restrained by staff using a series of techniques for escalating disruptive behavior on 12/29/2016 at 3:38 pm. Two video recordings, filmed from opposite ends of the hallway, capture the physical restraint techniques used by staff members Richard Gilbert and Shane Arsenault as ██████ was being transferred from one room to another.

In one recording (CH06_20161229_1558.exp) Gilbert is seen exiting ██████'s room at 15:28:06 and closes the door with effort as ██████ attempts to open it. Arsenault arrives to assist and at 15:28:19 Gilbert opens the door and grabs ██████'s left arm pulling him into the hallway as Arsenault grabs ██████'s right arm. Arsenault holds ██████'s right arm out to the side and places his left foot on ██████'s feet as Gilbert holds ██████'s left arm out to the side. ██████ is then pushed to the floor landing in a prone position. In the process it appears that the full body weight of Gilbert lands on ██████'s left upper back while ██████'s left arm is being held out to the side and behind him. The duration of the prone position is approximately 10 seconds (15:28:22 – 15:28:32). Arsenault and Gilbert lift ██████ to his feet by pulling upward on his arms and escort him toward the camera with Gilbert holding ██████'s left arm out to the side and back and Arsenault holding ██████'s right arm behind his back.

246 Pleasant Street, Suite 218, Concord, NH 03301, Tel (603) 271-1235, Fax (603) 271-6308

The other recording (CH07_20161229_1558.exp) shows the escort procedure from the rear but only partially shows [REDACTED] being assisted to his feet as the takedown occurred just out of view of the video camera. **In this recording Gilbert is holding [REDACTED]'s left arm out to the side while Arsenault is holding [REDACTED]'s right arm behind his back as he is being escorted down the hall away from the camera. There is no video recording showing the physical restraint technique previously reported by Gilbert inside [REDACTED]'s room nor is there any video recording showing [REDACTED]'s arrival inside the destination room.**

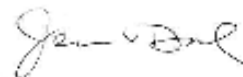
At approximately 3:50 pm, [REDACTED] was examined by a nurse for complaints of pain in his left upper arm. No redness or swelling was noted at that time but slight bruising was noted **"on outside of lower part of upper arm"** when reexamined at approximately 5:30 pm. The following day he was examined by a physician and complained of pain on raising the arm. X-rays were ordered and results were received on 1/3/2017 indicating a left scapula fracture. [REDACTED] was provided with a sling and referred to an orthopedic specialist. Repeat x-rays on 1/11/2017 showed a fracture through the distal body of the scapula with slight angulation. Clinical examination showed tenderness along the body of the scapula and mild discomfort with range of motion exercises. [REDACTED] was advised to modify activities and use ibuprofen and ice as needed for discomfort. Follow up x-rays on 2/22/2017 showed evidence of healing and clinical examination revealed full range of motion without discomfort. [REDACTED] was allowed to resume all of his usual activities and discharged from orthopedic care.

Because of its position, mobility and encasement in muscle tissue, the scapula is relatively protected from direct trauma and fractures are rare. When they do occur, the vast majority are the result of high-energy trauma as may occur with motor vehicle accidents and thus are often associated with other significant injuries. Scapula fractures resulting from low-energy trauma are rarely reported but have resulted from direct blows to the shoulder and from extreme muscle spasms as may occur with seizures and electrocution.

It is my opinion, that [REDACTED] sustained a fracture of his left scapula when he was physically restrained by staff members at the SYSC on 12/29/2016. The fracture most likely occurred during the takedown procedure in the hall outside of his room when staff member Richard Gilbert **landed on [REDACTED]'s upper back while holding [REDACTED]'s left arm away from his body.** Scapula fractures are rare and typically associated with high-energy trauma but occasionally result from low-energy trauma as in the present case.

Please do not hesitate to contact me again with any questions.

Sincerely,



Jennie V. Duval, M.D.
Chief Medical Examiner

Disability Rights Center – New Hampshire (DRC) is the Congressionally-mandated protection and advocacy system for people with disabilities in New Hampshire, including individuals with mental illness. DRC’s mission is to eliminate barriers existing in New Hampshire to the full and equal enjoyment of civil and other legal rights by people with disabilities. DRC, as well as the other 56 protection and advocacy systems throughout the country, have the authority under federal law to investigate incidents of abuse and neglect of individuals with disabilities and to pursue legal, administrative, and other approaches to ensure the protection of individuals with disabilities. Protection and advocacy agencies are authorized to engage in a wide variety of activities to protect individuals with disabilities and/or mental illness, including monitoring facilities, conducting investigations, issuing public reports, engaging in litigation, administrative hearings and other dispute resolution activities, and educating policymakers. DRC’s work to prepare, write, and distribute this report is funded under the Protection and Advocacy for Individuals with Mental Illness (PAIMI) grant.

The contents of this report are the sole responsibility of the Disability Rights Center - NH, Inc. and do not represent the official views of our federal grantors.