DISABILITIES RIGHTS CENTER, Inc.

Initial Investigation Report, Findings & Recommendations

On Allegation of Use-of-Force and Mechanical Restraint Against a Detained Youth at the John H. Sununu Youth Services Center on June 9, 2008

Prepared by the Disabilities Rights Center

January 2009

Richard Cohen, Esq.
Rebecca Whitley, Esq.
Disabilities Rights Center, Inc.
18 Low Avenue
Concord, NH 03301
(603)228-0432 (V/TTY)
1-800-834-1721
advocacy@drcnh.org
www.drcnh.org

DRC is the designated federal protection and advocacy system for New Hampshire and is a member of the National Disability Rights Network

TABLE OF CONTENTS **Page**

Executive Summary

The Disabilities Rights Center ("DRC"), after an extensive investigation,[1] substantiated an allegation of abuse and neglect committed by two residential youth counselors against a fourteen-year old male youth with emotional disabilities housed at the John H. Sununu Youth Services Center ("SYSC"). DRC is New Hampshire's designated Protection and Advocacy system for individuals with disabilities, and pursuant to federal law has the authority to conduct investigations of allegations of abuse and neglect committed against children and adults with disabilities.

The investigation, which is fully described in the accompanying report, found that two residential youth counselors at SYSC used unnecessary and excessive force against this fourteen-year old boy. The staff employed a take-down restraint in an extremely small space; dragged the youth face-down across the floor by his feet; and held him in a prone restraint for an indefinite amount of time. DRC found that the youth's behavior did not warrant the youth counselors' actions and that their actions were unnecessary, excessive and carried out in a manner that was abusive and dangerous. The investigation also found that youth counselors' actions contributed to and escalated the situation, causing the youth to further act out.

The youth had been subject to restraint on at least one other occasion at SYSC over a year ago, in which he suffered a fractured elbow.

DRC also reviewed SYSC's response, reporting and investigation of the allegation of abuse and found a number of failings, most of which appear to be systemic. The findings with

[1] The investigation was conducted by Rebecca G. Whitley, Esq. an attorney with the Disabilities Rights Center and was supervised by Richard Cohen, Esq., DRC's executive director and former member of the Eric L. Oversight Panel which monitored DCYF's compliance with the Eric L. Settlement Agreement, former director of the Division of Investigations of the Mass. Department of Mental Retardation, and author of "Best Practices in Abuse and Neglect Reporting and Investigation," a chapter in Bradley, V.J. & Kimmich, M.H. (2003) *Quality Enhancement in Developmental Disabilities.* Baltimore: Brookes Publishing.

regard to the incident, together with these additional findings, raise serious concerns about SYSC's systems of abuse prevention, reporting, investigation, correction and accountability, as well as the facility's treatment of children with mental illness.

DRC made the following additional findings:

1. SYSC staff failed to debrief the incident with the youth involved and/or with clinical and administrative staff in order to learn from the incident so as to prevent the same or similar incident from re-occurring and SYSC does not have a policy requiring staff. SYSC also does not have a policy requiring staff to de-brief the incident with the youth involved;

2. SYSC staff failed to follow internal policies and procedures in reporting the incident internally;

3. SYSC staff failed to report the incident to the NH Division for Children, Youth & Families ("DCYF") in violation of the child protection law, RSA 169-C:29;

4. SYSC failed to report the incident to either the NH Department of Justice ("DOJ") or the NH Department of Health and Human Services ("DHHS"), pursuant to RSA 169-C:37;

5. SYSC failed to develop a clear reporting policy for reporting abuse or neglect under RSA 169-C:37;

6. DHHS and/or DOJ failed to develop regulations, protocols and/or a mechanism for reporting institutional abuse and neglect pursuant to RSA 169-C:37;

7. SYSC's internal review and investigation of the incident was deficient. SYSC administration failed to follow internal policy and basic review and investigation standards and practices;

8. SYSC is a state-owned and operated facility and with the exception of the educational program, none of the facilities or programs at SYSC are licensed, certified, regulated, monitored or accredited by external agencies to ensure conditions, services and programs at SYSC meet safety, treatment, health and welfare standards.

DRC made the following recommendations:

Recommendations to the NH Division for Juvenile Justice Service ("DJJS") & SYSC Specific to this Case:

1) Develop appropriate concrete, specific, informed and behaviorally positive strategies, to therapeutically respond to the youth's behavior challenges;

2) Utilize an independent, qualified psychologist or other behavioral specialist to help develop and oversee the plan and approach;

3) Provide the youth a written apology for the harm he suffered while at SYSC due to failure of SYSC staff to follow policies, to provide a physically and emotionally safe place for him, and to provide an effective oversight of his stay there; and

4) Take the appropriate disciplinary action against the two employees for their actions.

General Recommendations to DJJS & SYSC:

1) DJJS should conduct a ***rigorous analysis of their current behavior management system*** to ensure it is in line with professional standards, overseen by an independent organization such as Juvenile Detention Alternatives Initiative ("JDAI"). At a minimum DJJS should review their current behavior management system, however we also strongly suggest that an organization such as JDAI review all of DJJS's policies and procedures as related to SYSC;

2) As there is considerable amount of literature on the life-threatening dangers of prone restraints, including numerous cases of asphyxiation and cardiac arrest, SYSC should ***immediately discontinue the use of prone restraint***;

3) Currently, SYSC policy permits staff to carry out physical interventions using "Joint Compliance Techniques" which "are designed to cause pain to a joint, which results in compliance." SYSC should ***immediately discontinue the use of pain compliance techniques***;

4) Establish and implement specific procedures to ensure ***staff*** report abuse and neglect pursuant RSA 169-C:37 and provide training to staff on how to report institutional abuse and neglect;

5) Establish and implement specific procedures to advise ***residents*** that they may report abuse and neglect pursuant RSA 169-C:37 and how to report institutional abuse and neglect;

6) Initiate and continue training of all staff on their mandatory responsibilities in reporting and addressing abuse and neglect;

7) Ensure that all staff receive training on appropriate management of the behavior of children with mental illness;

8) Ensure that counselors are available at all times;

9) Expand data collection on behavioral incidents to better track the occurrence of behavioral incidents (and eventually reduce restraint and isolation and improve staff intervention in behavioral incidents);

10) Institute a more extensive monitoring process of incidents of restraint and isolation, including regular restraint reviews involving an appropriately qualified consulting psychiatrist or psychologist who can review incident reports as a way to improve staff intervention in behavioral incidents; and

11) Provide DRC a written plan with timelines to implement the recommendations above.

Recommendations to DHHS:

1) Promulgate rules based on best practice professional standards for external oversight and monitoring of SYSC; and

2) Promulgate rules consistent with DHHS's authority to investigate reports of institutional abuse and neglect and to take the appropriate action for the protection of children pursuant to RSA 169-C:37 and RSA 169-C:3-a(III).

Further Investigation by DRC

Based on the information obtained in this case, DRC has initiated an investigation on a broader scope into possible systemic issues concerning the conditions of confinement for children with mental illness confined to SYSC, and SYSC's and other state entities' capacity to address allegations of staff abuse and neglect.

II. Introduction

The Disabilities Rights Center, Inc. ("DRC") received a report of an alleged incident of abuse against a confined youth at the John H. Sununu Youth Services Center in Manchester, NH ("SYSC")[2]. The report alleged that on June 9, 2008, two employees of SYSC used excessive force while restraining J.D.,[3] a fifteen-year old[4] confined youth with significant emotional disabilities. The alleged incident occurred on "G Unit". This was not the first time DRC had received a report of alleged abuse involving this particular youth. The previous year, DRC became aware of an incident of restraint by staff involving J.D. in which J.D.'s elbow was fractured.

Pursuant to DRC's authority as New Hampshire's designated protection and advocacy system ("P&A") for individuals with disabilities[5] DRC conducted an investigation of this latest incident. The evidence and our findings and conclusions are set forth in Part IV. DRC reviewed SYSC's response, reporting and investigation of this incident and obtained and reviewed SYSC's relevant policies to evaluate the system's incident response, practices, corrective and preventative actions, and its use, review and monitoring of restraint and seclusion. Part V

[2] The New Hampshire Division for Juvenile Justice Services ("DJJS"), a division within the New Hampshire Department of Health and Human Services, provides institutional services for juveniles and operates SYSC, New Hampshire's primary architecturally secure treatment and detention facility for juveniles.

[3] These are not the youth's real initials. The name of the youth has been changed to protect his confidentiality.

[4] J.D. was fourteen at the time of the alleged incident.

[5] DRC is authorized by federal statute to "investigate incidents of abuse and neglect of individuals with mental illness if the incidents are reported to the system or if there is probable cause to believe that the incidents occurred." *See* 42 U.S.C. § 10805(a)(1)(A). The DRC is a statewide organization that is independent from state government or service providers. As New Hampshire's P&A, the DRC carries out five protection and advocacy programs including Protection and Advocacy for Individuals with Mental Illness (PAIMI). 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 is also funded by the New Hampshire Bar Foundation.

summarizes DRC's review of these areas and Part VI contains DRC's recommendations regarding all findings and conclusions in this report.

Based on additional information we received from this incident, DRC will be issuing a second report addressing possible systemic issues it is still investigating, particularly with regard to SYSC's and other state entities' capacity to address allegations of staff abuse and neglect, and SYSC's behavior management system, including the use of discipline, use of force, restraints, and seclusion.

III. Summary of DRC's Investigation and Methodology

DRC conducted four different site visits at SYSC and interviewed the majority of staff members and other confined youth who were present on J.D.'s unit the evening of the alleged incident. Staff and youth were all interviewed separately. J.D. was first interviewed by DRC staff on June 12, 2008, just three days after the incident. The other site visits and interviews occurred on June 13, 16 and 19, 2008.[6] DRC interviewed the following staff members at SYSC:

1) John Duffy, Bureau Chief of Residential Services
2) Joseph Gardner, Youth Counselor III
3) Eric Leitner, Youth Counselor II
4) Melanie Nickerson, Treatment Coordinator
5) Caroline Stacy, Nurse
6) Connie Racine, Nurse
7) Kristen Mirabella
8) Becky Ball, Youth Counselor I

The names of the youth DRC interviewed are confidential. DRC also interviewed J.D.'s Guardian ad Litem ("GAL"), who is a DRC attorney. Our investigation included a visit to G Unit where we took photographs of J.D.'s room. Finally, DRC's investigation included a review of the following documents:

[6] Andrew Esterday, a DRC intern provided invaluable assistance in the investigation and interview process at SYSC.

1) Incident Investigation Report completed by Jim Peace, Senior House Leader and John Duffy, Bureau Chief of Residential Services
2) Two different DJJS Incident Reporting Forms completed by Nurse Connie Racine
3) DJJS Incident Report completed by Mr. Gardner and Mr. Leitner
4) Email Statement from Brian M. Bedard to John Duffy
5) Photocopy of photos taken by staff at SYSC
6) Nursing progress notes from 6/9/08
7) Statement from another confined youth
8) Incident Investigation Report completed by Jim Peace, Senior House Leader and John Duffy, Bureau Chief of Residential Services
9) SYSC's policies, procedures, protocols and processes for the restraint and seclusion of juveniles;
10) SYSC's training materials for the restraint and seclusion of juveniles; and
11) SYSC's policies, procedures, protocols and processes concerning reported incidents and allegations of abuse and neglect.

DRC requested video footage of the restraint in J.D.'s room and was informed by counsel for the Department of Health and Human Services ("DHHS") that there was not a security camera positioned to view J.D.'s room.

IV. Background and Previous Incident of Seclusion and Restraint

J.D. is a fifteen-year-old young man (DOB: 11/12/1993) with a history of major mental illness. His diagnoses have included depression/bipolar disorder, ADHD, ODD/conduct disorder, mixed substance abuse and a possible diagnosis of antisocial/borderline personality disorder. J.D.'s mental illness and related conditions have impacted his functioning across all environments and resulted in removal from home and placement at various residential facilities.

J.D. entered residential placement on March 15, 2007 at Odyssey House in Hampton, New Hampshire. He was discharged from Odyssey House after only a few weeks in the program following an incident with a staff member. J.D. was then sent to the SYSC Excel program for substance abuse treatment, where he resided from April 12, 2007 to August 2, 2007. During his time in Excel, SYSC staff had considerable difficulty managing J.D. and often used restraints and seclusion to manage his behavior. As a matter of practice, SYSC would lock youth

in their rooms for most of the day when they did not comply with the SYSC behavior management system.

During J.D.'s confinement at SYSC, both his GAL and Juvenile Probation and Parole Officer ("JPPO") had frequent contacts with SYSC staff to ensure that staff took a more individualized approach to J.D.'s needs, principally due to his mental illness. When J.D. was locked in his room for most of the day, he would often engage in self-injurious behavior and escalating disruptive behavior. His GAL and JPPO made attempts to have J.D. stay out of his room for significant periods of time and in the company of a staff member for more of the day. Despite these requests, there were a number of occasions when SYSC staff had to restrain J.D. in his room following a period of seclusion and escalating behavior. J.D.'s elbow was fractured during one particular restraint on July 29, 2007. J.D. received the injury during a restraint which staff members reportedly initiated to "protect J.D. from injuring himself." This incident is discussed further in the following section of this report.

J.D. then resided at Spaulding Youth Center ("Spaulding") from August 2, 2007 to May 5, 2008, when he was discharged after being found with marijuana on campus, an incident that involved several other children. After this incident and a violent outburst at home, Spaulding decided to terminate J.D. from the program, stating that J.D.'s progress had been "minimal." J.D. later said he had difficulty connecting with his therapist at Spaulding, although he was able to form positive relationships with some of the other staff. J.D.'s mother also observed positive changes in J.D.'s behavior at home resulting from the program at Spaulding.

When he left Spaulding, J.D. was transferred to the North Country Shelter in Jefferson, NH ("Jefferson") on May 5, 2008. At Jefferson, J.D. received information that led him to believe that he would be sent back to SYSC. In response to this news, J.D. decided to run away

along with two other residents. He was returned to the program only after a police search. Jefferson decided that they were no longer able to house J.D. and he was transferred to SYSC on May 22, 2008. Because J.D. reportedly made a threat to commit suicide if he were returned to SYSC, and because the parties had previously concluded that SYSC was not well-equipped to meet J.D.'s needs, the parties agreed that he would be transferred out of SYSC as soon as a suitable residential program could be obtained.

J.D. was at SYSC from May 22, 2008 until July 25, 2008, at which time he was transferred to Orion House as soon as a bed became available. Following a series of incidents at Orion House where J.D. was acting out, J.D. was returned to SYSC on September 17, 2008. The basis and justification for Orion's responses, including the transfer back to SYSC, remains in dispute. Neither DRC nor any other agency has investigated this matter, however. J.D. remains at SYSC to this date.

As noted above, during J.D.'s first stay at SYSC, one of the incidents of seclusion and restraint resulted in a fracture to J.D.'s elbow. On July 29, 2007, J.D. had been locked in his room after an incident in the cafeteria. While in his room, his behavior escalated and he began to punch and kick the door, throw property, and verbally threaten the staff outside. According to an incident report from SYSC, staff entered his room "to talk" but had to restrain him to "gain control." J.D. was restrained face down on his bed by three staff members until "he stated he would be compliant to staff orders." Another report indicated that J.D. was restrained until he "complied with staff directives and committed to safety."

J.D. says that his right arm was twisted so far up his back that it reached his neck and his elbow "popped." Immediately after the restraint, J.D. could not move his elbow, so SYSC staff took him the following day to have his elbow examined. The x-ray machine was broken and

staff from SYSC did not follow-up. The Physician Assistant who examined him wrote a week later on August 8, 2007, that J.D. had full range of motion and a case of "tendonitis."

On August 2, 2007, J.D. was transferred to Spaulding. His mother noticed on a visit that J.D. had a massive bruise on his arm and could not move his elbow properly. J.D.'s GAL spoke with him on August 3, 2007 and J.D. described the restraint incident and the lack of follow-up. At his GAL's request, J.D. eventually received an x-ray on his elbow. Although no fracture was found from that x-ray, follow-up with an orthopedic surgeon was recommended. J.D. saw the orthopedist on August 9, 2007 who found deep bruising and recommended follow-up in a few weeks and on September 18, 2007, Spaulding heard from the orthopedist that J.D.'s elbow actually had been fractured as a result of the restraint at SYSC.

J.D.'s GAL obtained a report of the incident from Penny Sampson, SYSC's clinical director on August 3, 2007, and met with John Duffy, head of SYSC, on August 29, 2007. Mr. Duffy believed that his staff used reasonable force and restrained J.D. for his own protection. Mr. Duffy provided documentation of the incident and agreed to follow up with documentation of SYSC's policies and training with regard to restraining children. Mr. Duffy later told J.D.'s GAL that he was not required to provide information regarding SYSC's restraint policies or training to the GAL and would not do so. J.D.'s GAL then requested that the Rochester District Court order DJJS to turn over its policies and training materials for restraint and seclusion. The court denied this request, ordering that the request was inappropriate discovery for a delinquency case. DRC did not conduct an investigation at that time because J.D.'s Mother wanted to consult with a private attorney.

According to J.D.'s GAL the July 29th incident was the latest in a long line of incidents of restraints and self-injurious behaviors. J.D. had been seen by a doctor for head and hand injuries in May 2007.

V. Findings and Conclusions Regarding Alleged Incident

A. Review of Evidence

DRC received another report of an incident of alleged abuse that occurred on June 9, 2008. The allegation was that two employees of SYSC again used excessive force while restraining J.D. and removing him from his room. The June 9 incident is the subject of this investigation. The following is a summary and analysis of the relevant evidence concerning the alleged incident of abuse at SYSC.

While there are different accounts of the alleged incident, there is general agreement as to the events leading up to the incident, as well as some aspects of the incident itself. The following represents what is generally agreed to: J.D. attended a court review hearing on the morning of June 9 and was informed that although he would be transferred to Orion House in Newport, NH, a bed was not yet available and he would have to remain at SYSC.

According to J.D.'s GAL, J.D. was visibly upset at the prospect of returning to SYSC. As a result, within an hour after the hearing, J.D.'s GAL emailed 1) the SYSC Chief of Residential Services, John Duffy; 2) the Clinical Director, Penny Sampson; and 3) the Treatment Coordinator Brian Bedard, advising them that J.D. was returning to SYSC and was clearly upset about it. His GAL requested that 1) someone meet and talk with J.D. upon his return; 2) that he be watched for self-injurious behavior; and 3) that J.D. be allowed more time out of his room and in the company of staff.

Despite J.D.'s state and his GAL's requests, no one met with J.D. when he first returned to SYSC. Instead he was immediately locked in his room on G Unit as a result of an incident unrelated to him that occurred before his arrival (the whole unit was on lockdown). J.D. was later let out for dinner, and then locked in his room again. While in his room, J.D.'s behavior escalated and verbal altercations with staff began. The staff responded by stripping his room down, leaving only a bed frame and a desk in his room. Joseph A. Gardner, Youth Counselor III, made the decision to strip J.D.'s room. When J.D. did not deescalate, he was taken to a treatment coordinator who spoke with him for forty-five minutes. The Treatment Coordinator then took him to a cell in Admissions, where he sat for an hour. J.D. was then returned to his room (still stripped bare) and verbal altercations with staff continued. At some point, Mr. Gardner and Eric Leitner (another SYSC youth counselor on duty that evening) decided to remove J.D. from the unit and entered his room to do so. Thereafter, the accounts diverge.

It is clear that J.D. was physically and mechanically restrained, during which J.D.'s face and back were scratched and bruised, leaving blood on the floor, desk and wall of his room. The allegation is that SYSC staff used excessive force when restraining J.D. and acted in an abusive and neglectful manner during the course of physically and mechanically restraining J.D. and removing him from his room.

1) J.D.'s Account of the Alleged Incident

The following is J.D.'s account. J.D. arrived at SYSC from court on Monday, June 9, 2008 at approximately 2:45 pm. He was admitted to intake, where he was stripped down and put in "state clothes." At approximately 3:00 pm he was escorted to G Unit and when he arrived, G Unit was in a lockdown over a fight that had occurred while J.D. was not there. Interviews with staff reveal that during lockdown, children are not permitted to talk in their rooms. J.D. was sent

straight to his room. While in his room, he played cards (cards had been banned from the rooms but he had snuck them in) and then went to dinner at 4:30 pm. At about 5:15 pm, J.D. and the other confined youths from G Unit were on their way back to the unit in a line, when someone ahead of J.D. (who was about a third of the way back) knocked on the door of H Unit as a joke. This resulted in another lockdown on G Unit because no one admitted to knocking on H Unit's door. According to J.D., all the confined youth went to their rooms "mad".

Before the incident leading to this second lockdown, staff had handed out snacks to all the residents on G Unit. When the lockdown went into effect, J.D. took his snack and hid it in his shirt, because snacks are not allowed in the rooms during the lockdown. Following the lockdown, Mr. Gardner was at the doorway to J.D.'s room and asked him if he had the snack in his shirt. J.D. then pulled the snack out of his shirt and held it in his right hand. Mr. Gardner then grabbed J.D.'s wrist and twisted it outwards so J.D. had to let go of the snack. According to J.D., Mr. Gardner continued to twist his arm. Because J.D. was afraid that there would be a recurrence of the injury to his elbow (this was the arm that was injured last year), he "freaked out" and started swearing and calling Mr. Gardner names. Mr. Gardner then let go and shut the door to J.D.'s room. The doors in the Unit automatically lock when they are shut. Mr. Gardner denies twisting J.D.'s arm, and no other witness saw what happened.

After J.D.'s snack had been taken away, J.D. went to his desk in his room and sat down and shuffled cards for a while. Because the rooms in the Unit echo, the card shuffling was apparently noisy enough for staff members to hear. Another staff member on duty, Amy Allaire told him to "knock it off." In response, J.D. put the cards back in the pack and tossed it at the door. Another staff member, Becky Ball and Ms. Allaire came in at that time and retrieved the card pack from J.D. and shut the door. At this point, Mr. Gardner came downstairs where the

rooms are located and asked what was going on. Mr. Gardner made the decision at that point to "strip" J.D.'s room, meaning that staff removed everything from his room except for the desk and bed-frame.

After his room was stripped, J.D. sat on the bed frame. Because his cards were gone and J.D. reported he had been using the cards as a coping skill, he then began tapping on his desk. Without the cards, he continued to tap on his desk, admittedly because he knew at this point that the noise was annoying people. He then got up and started pushing on the door. J.D. reported that there is an area near the hinge on the door that makes a noise if you push at it. He also began yelling at Mr. Gardner and calling him names, because according to J.D., Mr. Gardner kept walking by and grinning at him like he thought it was funny that J.D. was in his room with none of his things.

After a while, J.D. was taken up to the main floor to talk to Melanie Nickerson, a Treatment Coordinator at SYSC. Melanie told him that if he kept on behaving this way he would be taken to H Unit or to the cell in Intake. J.D. volunteered to go back to Intake because he was afraid of getting into more trouble. He arrived back at Intake at 6:40 pm and sat there for around an hour, until Ms. Ball brought him back to G Unit. J.D. overheard Ms. Ball asking Mr. Gardner whether J.D. could have his things back in his room and Mr. Gardner responded that he would return them in a couple of minutes.

At that point, J.D. was back in his room. After about forty-five minutes in his room, Mr. Gardner had not returned J.D.'s things, so J.D. pressed his buzzer. According to J.D., Mr. Gardner was in the office on the floor of the Unit and shut off the intercom so he did not have to listen to the buzzer. J.D. started yelling and pushing at the door to his room as a result. J.D. heard Mr. Gardner say he was an idiot.

About thirty minutes later, J.D. was doing push ups in his room to calm down, when the lights went on. He went to the door to see what was going on. Mr. Gardner was at the door and Mr. Leitner was apparently behind him. (According to Mr. Gardner and Mr. Leitner, Mr. Leitner unlocked J.D.'s door from the "bubble", the central control room of the Unit, and Mr. Gardner went into J.D.'s room first with Mr. Leitner following him.)

According to J.D., when Mr. Gardner opened the door, J.D. called him a "faggot" but only got about half the word out when Mr. Gardner lunged at J.D. and grabbed his shirt. J.D. denies trying to punch Mr. Gardner. Mr. Gardner pushed J.D. back and J.D. lost his balance and fell in the narrow space between the bed and the desk, hitting his face on the desk. Mr. Leitner came in and grabbed his ankles and dragged him out to the middle of the floor, with his face scraping the floor. J.D. tried to lift his upper body but Mr. Gardner then dropped to his knees on J.D.'s back. Mr. Gardner kneed J.D. in the back three or four times. J.D. tried to lift his face off the floor where he was bleeding, but Mr. Gardner used his knee to push J.D.'s head back down on the floor. J.D. was swearing, but physically complaint. Mr. Leitner told him to put his hands behind his back and he was handcuffed. Mr. Leitner had his knees pinned down as well.[7]

Mr. Leitner or Mr. Gardner then picked J.D. up by the handcuffs and pants and pushed him against the wall, grabbing him by the back of his shirt collar. J.D. had marks on his wrists where the handcuffs were. Mr. Leitner stood J.D. up and Mr. Gardner asked him if he had anything else to say. J.D. called Mr. Gardner some more names. Mr. Gardner grabbed J.D.'s head and tried to push his head into the wall but J.D. turned his head to the side and jerked to try to avoid the wall. J.D.'s face made contact with the wall. Bloodstains were found on the floor and wall.

[7] According to all reports, once Mr. Leitner entered the room, his back covered the small window on J.D.'s door. No one could see into the room and therefore there were no other witnesses to the actual incident of restraint, other than J.D., Mr. Gardner and Mr. Leitner. There are no video cameras in the children's rooms.

J.D. was then taken back to Intake and he was stripped down except for his shorts. He was told that his clothes were removed because he was a risk to himself and because he had "banged his head on the wall" himself. On the way to Intake, J.D. reported that Mr. Gardner and Mr. Leitner had told the other kids that "this is what happens when you try to attack staff." J.D. eventually told one of the nurses what had happened and she wrote down everything. The nurse that J.D. met with was Nurse Connie Racine. (While Mr. Gardner and Mr. Leitner report that J.D. was verbally abusive to Nurse Racine, she denies this allegation. Nurse Racine reported that J.D. initially would not allow her to assess him; however she did make observations while standing outside the intake room.) Nurse Racine eventually assessed J.D. and it was during this second assessment that J.D. reported the incident in his room to her.

J.D. reported that no one discussed the incident with him, and that he was punished for this incident pursuant to SYSC's discipline policies. According to an SYSC Incident Report, the youth counselors who restrained J.D. recommended 5 days of OOC and 5 additional days OOC upon administrative approval. "OOC" stands for "Out of Community", a punishment where for a defined period of time, the resident is restricted from engaging in social activities with peers/staff following a rule violation. J.D. also stated that he reported the incident to Kristin Mirabella, Nurse Connie Racine, Brian Bedard and later to this investigator.

Finally, J.D. reported that staff regularly abuse youth in their rooms, because the cameras cannot see in. He also reports that staff regularly use more force than necessary and to deliberately inflict pain.[8] (This was corroborated by a number of residents DRC interviewed.)

DRC interviewed a number of the other residents on J.D.'s unit. These interviews did not reveal much about what occurred in J.D.'s room on June 9th. Some of the boys reported they

[8] SYSC Policy#C-003 permits staff to carry out physical interventions using "Joint Compliance Techniques" which "are designed to cause pain to a joint, which results in compliance."

cannot see inside J.D.'s room from their room. The boys who reported that they normally can see into J.D.'s room, reported that on this particular evening, they could not see anything because one of the staff members' back was covering the small window on J.D.'s door, thus blocking their view into his room.

2) Mr. Gardner and Mr. Leitner's Accounts of the Alleged Incident

DRC interviewed both Mr. Leitner and Mr. Gardner in addition to reviewing an incident report they drafted the night of the incident. Their portrayal of the timing of the night was very similar to J.D.'s. However, their portrayal of the events leading up to the incident; what occurred in J.D.'s room; and the nature of the restraint varied from J.D.'s.

Mr. Gardner reports that J.D. was being extremely disruptive to the Unit as a whole the entire evening. Mr. Leitner reports that when he came into work that evening, he received a call that J.D. had made a "disturbance" at court. Mr. Gardner reported that he knew J.D. was a "special case" and tried to redirect him the entire evening and gave him a number of directives, like "sit on your bed" and "stay away from your window." When J.D. would not comply and continued to cause a disruption, Mr. Gardner called a clinician, Melanie Nickerson, as a last resort. Ms. Nickerson was called only after Mr. Gardner had "stripped" J.D.'s room. Mr. Gardner reports that he took all unsafe things out of J.D.'s room because of J.D.'s history of self mutilation.

Later that evening, when J.D. returned to his room, Mr. Gardner reports that J.D. started to "act up" again in his room and Mr. Gardner felt J.D. was being a threat to himself. According to the incident report, it was at that point that Mr. Gardner and Mr. Leitner "made the decision to return the resident back to Intake for interfering with the orderly operation and security of the unit." They report they gave J.D. several directives to stop his behavior and J.D. refused. Before

they entered his room, Mr. Gardner and Mr. Leitner report they gave J.D. three directives to back away from the door. When J.D. did not comply, they reported that they intended to enter his room and remove him from the unit using handcuffs, a form of mechanical restraint. Mr. Gardner reports that J.D. met them with clenched fists when they opened the door and Mr. Gardner asked J.D. to turn around so they could handcuff him. When J.D. refused to turn around, Mr. Gardner placed J.D. in a "one arm take down" and "placed him on the ground with his head near the bed and desk area face down", according the incident report. In his interview, Mr. Gardner described the restraint technique. The union representative present during the interview characterized the restraint as the "least restrictive restraint." Mr. Gardner stated in the incident report: "I placed my right hand on Resident's left fore-arm to gain arm control. I then slid my right hand to Resident's left shoulder and placed my left hand on the residents left fore-arm and using the one arm take down to the resident to the floor." Mr. Gardner reports that J.D.'s head was between the desk and bed face-down when J.D. reached the floor. The report does not mention that J.D. hit his head on either the desk or the bed.

Mr. Gardner stated in an interview that he was not paying attention to J.D.'s head during the take down and did not see J.D.'s head hit anything. He reported that he did not see any blood and had clear control of J.D.'s shoulder and arm. Mr. Leitner reports that he saw Mr. Gardner with J.D. in a one arm takedown. He stated that this is a technique they are taught at the "Academy."

Although it is not mentioned in the incident report, Mr. Leitner stated in his interview that he pulled J.D., by his feet, away from between the desk and bed to apply the handcuffs. J.D. was still face-down when he was pulled to the center of the room. Mr. Leitner's incident report

indicated that J.D. received a "small scratch" as a result of being "placed on the ground during the restraint".

Mr. Leitner then reports that once J.D. was "secured on the ground" he assisted Mr. Gardner by "controlling the resident's lower body." According to the incident report, once J.D. was "under control", Mr. Leitner applied the handcuffs. J.D. was face-down this entire time. It is unclear from any of the reports how long J.D. was in this face-down, or prone restraint. Neither youth counselor remembers J.D. hitting his head on the desk or bed, but said he banged his head off the wall several times in Intake. As to J.D.'s statement that Mr. Gardner kneed him in the back, shoulders and head while he was face-down and cuffed, but Mr. Gardner and Mr. Leitner deny this allegation.

Once Mr. Leitner had handcuffed J.D., Mr. Gardner stood him up and put him against the wall with the side of his face against the wall. Mr. Leitner saw Mr. Gardner bring J.D. up with one hand on J.D.'s shoulder and place him against the wall and said it was J.D. who "bounced his head against the wall" a few times before they both escorted him back to Intake. When they got to Intake, the youth counselors had J.D. kneel down and removed the handcuffs only after J.D. "committed to safety." There is no documentation how long J.D. was in mechanical restraints.

Mr. Gardner reports that he felt the entire incident was appropriate and that the restraint was "textbook." He also said that J.D. has a history of false allegations. Melanie Nickerson, a Treatment Coordinator, also reports that J.D. has a history of "attention seeking allegations." Following the incident, Mr. Leitner completed an incident report and Mr. Gardner reviewed the report as Mr. Leitner's supervisor. Neither youth counselor completed a "Use of Mechanical

Restraints Sheet" or an "Incident Report Review Form" for the "Use of Mechanical and/or Physical Restraint Review Board."

3) Nurse Connie Racine's Account of the Alleged Incident of Abuse

DRC interviewed Nurse Connie Racine and reviewed her incident reports of that evening. Following the incident in J.D.'s room, J.D. was taken to Intake by Mr. Gardner and Mr. Leitner. Nurse Racine attempted to immediately assess J.D., but he would not allow this at first. She did however make observations of J.D. from outside the room. She observed an abrasion on J.D.'s left cheek and a bump on his forehead.

Nurse Racine reported that between her two assessments of J.D., she had two conversations with other staff members that were noteworthy. Nurse Racine reports she was in the medical area when another staff member, Kristin Mirabella entered the room. Ms. Mirabella reported to both Nurse Caroline Stacy and to Nurse Racine, much of the same information J.D. later told Nurse Racine and much of the same information she later put in her incident report. Nurse Racine then told Ms. Mirabella that due to the seriousness of the allegation, Ms. Mirabella needed to "report" this information. Instead, Nurse Racine reports that Ms. Mirabella "turned from the desk area, proceeded to the door, turned, gave a facial grimace, rolled her eyes and pointed to the "ENOUGH" button she was wearing and walked out." Nurse Racine took this to mean that Ms. Mirabella was not going to report the alleged abuse.

Nurse Racine also reported that she had a similar run-in with another staff member, Evelyn Clark-Smith. Sometime that evening Mr. Clark-Smith told Nurse Racine that J.D. had been giving Mr. Gardner a "hard time." Nurse Racine reported that she also told Ms. Clark-Smith that she is required to "report" J.D.'s allegations. Ms. Clark-Smith's response was that Mr. Gardner had an interview in June for a JPPO position and "this doesn't look good for him."

When Nurse Racine went to assess J.D. a second time, another staff member came with her. When Nurse Racine asked J.D. what happened, she observed that J.D. would not speak while this other staff was in there. Nurse Racine asked the staff to leave and J.D. spoke freely about what had just occurred. In addition to her assessment, Nurse Racine also documented J.D.'s allegations on an incident report and in her progress notes. J.D.'s report of the evening to Nurse Racine was almost identical to what he reported to DRC as documented in section IV(A)(1) of this report.

Nurse Racine also reported that J.D. was tearful at times during the conversation. She noted his visible apprehension to speak in front of the other staff member and reported that J.D. was not at all verbally assaultive to her, contrary to Mr. Gardner and Mr. Leitner's allegation. When DRC asked Nurse Racine whether she thought J.D. was reporting the incident accurately, she indicated she has worked with children a long time and trusts them until she has a reason not to. She indicated she had no reason not to believe J.D. in this case. She could tell that J.D. was very upset and she knew something was not right. She also reported that the injuries J.D. sustained (a bruise on cheek and scratch on back) were not normal for an appropriate restraint.

Medical progress notes documented Nurse Racine's medical assessment of J.D. following the incident and included: 1) abrasion left cheek approximately 2" diameter; 2) 1" bump reddened middle of his forehead along hairline; 3) both wrists reddened; 4) left armpit reddened; 5) reddened area left upper chest area near left armpit; 6) four superficial scratches on back ranging in size 4" to 2" in length.

4) Credibility and Competence of Individuals Interviewed

The only actual witnesses to the incident in J.D.'s room were J.D., Mr. Gardner and Mr. Leitner. Most of what went on was in J.D.'s room and could not be viewed by other youth. No

other staff was present when the restraint occurred. Given conflicting accounts of the incident, DRC probed further to ascertain the credibility and competence of the individuals interviewed and determine which account of the alleged incident was most accurate.

The substantial divergence came from the witness' characterization of the use-of-force and mechanical restraint that occurred in J.D.'s room. It is determined that the account of the incident given by J.D. is more credible than the account given by Mr. Gardner and Mr. Leitner and more likely represents what occurred.

First, J.D. reported an almost identical portrayal of the incident in great detail to a number of different people, including Ms. Mirabella, Nurse Racine, Brian Bedard, his GAL and to this investigator. Most of these reports were made immediately after the incident and before J.D. had time to process what had happened. J.D. remained consistent when he detailed to his GAL what happened, three days after the incident, and to this investigator, four days after the incident.

Second, J.D. was visibly very upset when recounting the events to Nurse Racine immediately after the incident occurred. J.D. was also visibly afraid of staff and of staff reprisal when recounting the incident to Nurse Racine and to this investigator. J.D. clearly felt intimidated by staff and did not feel entirely safe expressing his grievance in front of certain staff members. While Mr. Gardner alleged that J.D. has a history of false allegations and Ms. Nickerson indicated that J.D. has a history of attention-seeking allegations, the evidence discussed above did not support Mr. Gardner and Ms. Nickerson's allegation in this instance. Additionally, this investigator's review of the record and a statement from J.D.'s GAL also did not support this allegation.

Third, Mr. Leitner and Mr. Gardner's accounts were not written immediately after the incident. Immediately following the incident, Mr. Leitner and Mr. Gardner did not complete a

separate witness statement. Instead, according to Mr. Leitner, he created the incident report and Mr. Gardner reviewed it as his supervisor. Mr. Gardner then relied heavily on the incident report during the interview instead of answering our questions and recounting the events of the evening from memory. The youth counselors admit that the first report drafted was not saved on the computer and they had to re-type it the evening of the incident.

Fourth, the independence of Mr. Leitner and Mr. Gardner's statements is suspect at best. In addition to drafting the incident report, Mr. Gardner and Mr. Leitner had a number of opportunities to corroborate their versions of the incident. When DRC arrived at SYSC to conduct interviews on June 16, 2008, Mr. Gardner initially refused to be interviewed. Before he consented to an interview, this investigator observed Mr. Gardner meet Mr. Leitner outside of the facility on Mr. Leitner's way into work and have a discussion before coming back into the facility. Both youth counselors eventually agreed to be interviewed. While DRC did not hear their conversation, given the described chain of events and the way in which the written accounts were prepared, this brief meeting between the two youth counselors raised further suspicion about their account.

Fifth, when DRC finally interviewed Mr. Gardner and Mr. Leitner both staff members requested that a union representative be present during their respective interviews. While requesting a union representative is clearly within their rights, the same union representative was present for both interviews and he displayed problematic manners during the interview.[9] The union representative often prompted certain "correct" responses from both Mr. Gardner and Mr. Leitner. For example, when asked what particular technique was used to restrain J.D., Mr.

[9] Appropriate protocol in such situations generally requires that a representative not prompt an answer during the interview, but merely offer additional comments in explanation at the end. *See* National Labor Relations Board v. J. Weingarten, Inc., 420 U.S. 251 (1975) and Southwestern Bell Telephone Co. v. National Labor Relations Board, 667 F.2d 470 (1982), the former of which the youth counselors asserted as the basis for their right to be interviewed with a union representative present.

Gardner answered a "one-arm take down" and the union representative added "the least restrictive restraint."

Sixth, there also appears to be several key misrepresentations of fact by Mr. Leitner and Mr. Gardner. One is that J.D. became verbally assaultive towards the treating nurse the evening of the incident. Nurse Racine denies this allegation. The second is that J.D. was disruptive at court earlier that day. J.D.'s GAL was at court that day and reports that J.D. did not make any sort of disturbance at court but was only visibly upset at having to return to SYSC. The third is that J.D. hit his head during the restraint. Although the evidence clearly supports the fact that J.D. hit his head on the desk when he was taken down by Mr. Gardner, Mr. Gardner and Mr. Leitner continue to deny this fact. They also appeared to be covering it up by consistently reporting that J.D. was banging his own head numerous times throughout the evening. Even if J.D. did bang his own head at some point that evening, both youth counselors admit that J.D. fell face first between his bed and desk when he was taken down. Based on how small the space is between the bed and desk, it is far less likely that J.D. did ***not*** hit his head. This investigator also observed and took pictures of blood on both the floor between the bed and the desk and on J.D.'s desk. DRC also obtained pictures taken by staff at SYSC of J.D.'s room showing blood on both the floor and the side of J.D.'s desk.

Seventh, both Mr. Gardner and Mr. Letiner contend that they did nothing incorrectly that evening and that the incident of restraint was "textbook." There was not concurrence on this issue from other staff members. Nurse Racine indicated she knew something had "gone on" by the way everyone was acting and by the fact that J.D. did not want to talk until another youth counselor was out of room. Ms. Ball also reported in her interview that she felt the situation

could have been avoided and sounded like an out-of-the-ordinary type of incident. She characterized the whole situation as "bizarre."

There were other factors that reinforced DRC's determination that J.D.'s allegations were credible and led us to question the credibility of Mr. Letiner and Mr. Gardner. It appears from the evidence that some staff felt the need to cover up for Mr. Gardner and Mr. Leitner that evening. Even though Ms. Mirabella and Ms. Clark-Smith were aware of the serious allegation and were encouraged to report the incident, they chose not to. Ms. Clark-Smith even went so far as indicating that this incident did not look good for Mr. Gardner, and did not report it. Ms. Clark-Smith also attempted to corroborate Mr. Leitner and Mr. Gardner's claims that J.D.'s head injuries were solely from self-injurious behavior even though Nurse Racine did not witness this.

Finally, DRC considered the fact that although Nurse Racine was not a witness to the actual restraint she had salient information to report and encouraged others to take the allegation seriously. Nurse Racine may have had and felt more independence then other staff. She indicated to DRC that she was a contract employee at SYSC, not a regular employee. Her characterization of the incident was that J.D.'s injuries were unusual for a normal restraint. She also indicated that although some staff said that they saw J.D. bang his head, she did not witness any head-banging when observing J.D..

B. Definitions of Abuse and Neglect

The following is a review of the definitions of abuse and neglect that have applicability to this incident.

- New Hampshire Child Protection Act, RSA 169-C:3(II), defines an "abused child" as "any child who has been: (a) Sexually abused; or (b) Intentionally physically injured; or (c) Psychologically injured so that said child exhibits symptoms of emotional problems generally recognized to result from consistent mistreatment or neglect; or (d) Physically injured by other than accidental means;

- RSA 169-C:3(XIX) defines a "neglected child" as any child "…(b) Who is without proper parental care or control, subsistence, education as required by law, or other care or control necessary for his physical, mental, or emotional health, when it is established that his health has suffered or is very likely to suffer serious impairment; and the deprivation is not due primarily to the lack of financial means of the parents, guardian or **custodian**…" (Emphasis added);

- With regard to institutional abuse and neglect (abuse and neglect occurring in a public or private residential home, institution or agency), the Child Protection Act empowers the New Hampshire Department of Justice ("DOJ") and the New Hampshire Department of Health and Human Services ("DHHS") to receive and investigate reports of institutional abuse or neglect.[10] *See* RSA 169-C:37. The Act does not provide any guidance on how to report institutional abuse and neglect. The Act does, however require DHHS to promulgate rules consistent with their authority to investigate reports of institutional abuse and neglect and take appropriate action for the protection of children." *See* RSA 169-C:37 and RSA 169-C:3-a(III). These rules have not yet been promulgated;

- Regulations promulgated by the Substance Abuse and Mental Health Services Administration (SAMHSA) within the United States Department of Health and Human Services, define "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 but is not limited to acts such as: rape or sexual assault; striking; **the use of excessive force when placing an individual with mental illness in bodily restraints**; the use of bodily or chemical restraints which is not in compliance with Federal and State laws and regulations; verbal, nonverbal, mental and emotional harassment; and any other practice which is likely to cause immediate physical or psychological harm or result in long-term harm if such practices continue. *See* 42 C.F.R. § 51.51.2. (Emphasis added); and

- The SAMHSA regulations also define "neglect" as "a negligent act or omission by an individual responsible for providing services in a facility rendering care or treatment which caused or may have caused injury or death to an individual with mental illness or which placed an individual with mental illness at risk of injury or death, and includes, but is not limited to, acts or omissions such as failure to: establish or carry out an appropriate individual program or treatment plan (including a discharge plan); provide adequate nutrition, clothing, or health care; and the failure to provide a safe environment which also includes failure to maintain adequate numbers of appropriately trained staff. *See* 42 C.F.R. § 51.51.2.

[10] The Act defines "institutional child abuse or neglect" as "situations of known or suspected child abuse or neglect wherein the person responsible for the child's welfare is a foster parent or is an employee of a public or private residential home, institution or agency." *See* RSA 169-C:3(XVI.).

C. Standards for Use of Force and Mechanical Restraints

There is a clear consensus in research-based literature that use of force restraint should only be used in emergency situations and only after all less restrictive interventions have been attempted. This is especially important in that juvenile justice facilities detain many children will mental illness who may have been previously or even repeatedly traumatized. According to Dr. Eric Vance, DJJS's medical director, 68 – 80% of children in the juvenile justice system have a mental illness. He estimates 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 Post-Traumatic Stress Disorder ("PTSD").[11] Juvenile justice facilities should develop policies and practices that meet professional standards that best ensure the heath and well-being of children in detention.[12] Facilities should remain cognizant that children in detention are not adults and should thus keep adolescent development in mind when developing practice and policies. [13]

There is also a clear consensus that the safety of the child in juvenile justice facilities should be of utmost importance. In general, "[u]se-of-force restraints are inherently dangerous. They pose the risk of injury to the staff executing the restraint as well as the youth being restrained. They tend to escalate the emotional state of many adolescents and can re-traumatize youth with histories of abuse."[14]

---

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

[12] The Juvenile Detention Alternatives Initiative ("JDAI"), launched by Annie E. Casey Foundation, created a conditions assessment instrument that contains standards for juvenile justice facilities based on constitutional and statutory law, case law, and professional standards. These standards are widely recognized and used to train assessment teams in over eighty JDAI sites around the country. The JDAI standards are available at http://www.jdaihelpdesk.org/conditions/Pages/SelfAssessmentToolsandGuidelines.aspx.

[13] Sue Burell, Youth Law Center. "Improving Conditions of Confinement in Secure Juvenile Detention Centers." A project of the Annie E. Casey Foundation.

In a position statement, Mental Health America (formerly known as the National Mental Health Association) states that "seclusion and restraints have no therapeutic value, contribute to human suffering, and have frequently resulted in severe emotional and physical harm, and even death"[15]. Mental Health America therefore "urges abolition of the use of seclusion and restraints to control symptoms of mental illnesses."

Recognizing the balance of responsibilities in detention facilities between providing a safe and humane confinement environment and ensuring public safety, use-of-force restraints may be necessary in extreme emergency situations. As part of the Juvenile Detention Alternatives Initiative ("JDAI"), launched by Annie E. Casey Foundation, JDAI created a conditions assessment instrument that contains standards based on constitutional and statutory law, case law, and professional standards. These standards are used to train assessment teams in over eighty JDAI sites around the country.

The JDAI standards provide that if the use of force, restraints or isolation is necessary, they should be preceded by less restrictive techniques, including talking with youth to de-escalate the situation and bringing in other staff, mental health professionals, or other youth. The JDAI standards encourage a graduated set of interventions that avoid the use of physical force or mechanical restraints; employs a range of interventions or actions before using force or restraints; and permits only that amount of force needed to ensure the safety of the minor and others.

---

[14] Judith G. Storandt, Esq., National Disability Rights Network, "Use of Force in Juvenile Correctional Facilities", 3/03/06. Pg. 16.

[15] "Position Statement 24: The Use of Restraining Techniques and Seclusion." Mental Health America. Available at http://www.mentalhealthamerica.net/go/position-statements/24.

The JDAI standards also prohibit restraining youth in a prone position and putting pressure on the youth's back.[16] There is considerable amount of literature on the life-threatening dangers of prone restraints, including numerous cases of asphyxiation and cardiac arrest.[17] Finally, the standards prohibit the use of pain compliance techniques at facilities.

In another position statement, Mental Health America states that "[w]hen restraint must be used to prevent injury to self or others, there should be stringent procedural safeguards, limitations on time, periodic reviews and documentation" and that "these techniques should be used only in response to extreme threats to life or safety and after other less restrictive control techniques have been tried and failed." [18]

If restraint becomes necessary in an emergency situation, the safety of the child should be of utmost importance. The Council of Juvenile Correctional Administrators (CJCA) states in their position paper on physical and mechanical interventions with juvenile offenders that when "preventive measures fail, physical interventions and restraints should only be done by trained individuals and only used defensively and in a manner that provides maximum safety for the staff and youths."[19]

---

[16] JDAI Assessment Tool available at http://www.jdaihelpdesk.org/conditions/Pages/SelfAssessmentToolsandGuidelines.aspx.

[17] *See, e.g.,* 1) Stephan Haimowitz, et al., Restraint and Seclusion: A Risk Management Guide, September 2006, National Technical Assistance Center for State Mental Health Planning, *available at* http://www.nasmhpd.org/general_files/publications/ntac_pubs/R-S%20RISK%20MGMT%2010-10-06.pdf; and 2) Series of articles published in the *Hartford Courant* in 1998 chronicling the many deaths of adults and children resulting from the improper use of restraint in mental health facilities. Weiss, E., *et al., Deadly Restraint: A Nationwide Pattern of Death*, Hartford Courant (Oct. 11, 1998).

[18] Position Statement 51: "Children With Emotional Disorders In The Juvenile Justice System". Mental Health America. Available at http://www.mentalhealthamerica.net/go/position-statements/51.

[19] CJCA Position Paper on: Physical and Mechanical Interventions with Juvenile Offenders. Available at http://cjca.net/photos/content/documents/Interventions.pdf.

SYSC policy, however, permits the use of use-of-force restraints in non-emergency situations and permits the use of pain compliance techniques.[20] Staff are permitted to use force to prevent resident disturbances and to maintain order within SYSC. SYSC policy provides that "staff should respond using the least amount of force necessary to move the resident to the time-out room." SYSC staff are permitted to use "Aggression Management Techniques" if residents refuse to move to a "time-out room." SYSC policy defines the use of force as any time staff "apply any degree of physical force to influence client behavior" and that the use of force "must be reasonable for the existing circumstances."[21]

SYSC policy also provides that mechanical and/or physical restraints "shall only be used after ***less restrictive*** behavioral interventions have been attempted and a determination has been made that the continued use of less restrictive interventions poses a greater risk/threat to the resident or others than the use of mechanical restraints."[22] (Emphasis added).

Excessive use of force during a restraint can occur if:

1. "the restraint was not "authorized" and hence staff did not use the least restrictive approach to managing the youth's behavior during the incident (e.g., there was insufficient grounds for staff to believe that force was necessary);

2. the nature of the force employed was not an approved method of behavior management (e.g., choke holds; punching in the stomach; slamming against a wall);

3. the method used was not the least amount of force needed to manage the incident because an alternative means of force/control was reasonably available (e.g., a take-down was used when a reasonable caretaker, considering the age, gender and strength of the parties involved and the number of staff available, would have been able to control the situation using a standing restraint);

[20] SYSC Policy# C-003: Use of Force. This policy was not in effect on June 9, 2008. SYSC did not have a policy regarding the Use of Force at the time of the alleged incident discussed in this report. The effective date of Policy #C-003 was October 1, 2008.

[21] SYSC Policy #C-003: Use of Force.

[22] SYSC Policy 3-A-15: Use of Mechanical and/or Physical Restraints.

4. the method was improperly executed in a manner that harmed the youth or exposed the youth to the risk of harm (e.g., executing a take-down in a crowded location where it was likely that the youth's head would come into blunt contact with furniture; a take-down not executed as staff were trained to do it; during a prone restraint, staff sitting on the youth's back in a manner that put excessive pressure on internal organs; failure to protect a prone youth's face from injury);

5. the hold was authorized by the situation and consistent with the need for force but the staff used greater force than appropriate and needed (e.g., pulling the youth's arms behind his back more forcibly than appropriate); and/or

6. the youth was restrained longer than necessary to bring the situation under control (e.g., it was not limited to the time needed for the youth to regain control of his or her behavior)."[23]

Finally, the New Hampshire Legislature articulated the general standard of care that should be applied at SYSC. *See* RSA 621:2. This section provides that SYSC should "provide a wholesome physical and emotional setting for each child detained at or committed to the center"; and "provide protection, care, counseling, supervision, and rehabilitative services as required by the individual child."

D. Finding and Conclusions

Based on a preponderance of evidence standard, we find that Mr. Gardner and Mr. Leitner committed abuse as well as neglect against J.D.. Their actions were unnecessary, excessive and carried out in a manner that was abusive and dangerous. Their actions also escalated the situation and caused J.D. to act out.

The behaviors J.D. engaged in did not warrant the actions that Mr. Gardner and Mr. Leitner's engaged in. Although the methods and type of the force employed was an approved

[23] Judith G. Storandt, Esq., National Disability Rights Network, "Use of Force in Juvenile Correctional Facilities", 3/03/06. Pg. 18.

method of behavior control at SYSC,[24] there were insufficient grounds for staff to believe that force was necessary. J.D. was not restrained for his own safety, or to prevent injury, or for him to regain control. Instead the staff involved made the decision to remove J.D. from the unit for being disruptive and removed him using physical force and mechanical restraints. Mr. Gardner indicated that the reason he used force to restrain J.D. was because J.D. refused to turn around to be hand-cuffed and removed. These were insufficient grounds for the use of extremely restrictive behavioral interventions. No other alternatives were used to calm J.D. down and stop the disruptive behavior or to persuade J.D. to turn around. Both YCs stressed to this investigator that it was their job to keep the Unit safe and that they would do what they needed to do so. However there was no evidence that the Unit was unsafe or, as indicated, that physical force and restraint were otherwise needed.

Mr. Gardner and Mr. Leitner also failed to properly assess (or get someone who could properly assess) the behaviors that J.D. was engaging so that that the causes of his behavior could have been identified and addressed. A proper assessment of the situation would have prompted a much different and less intrusive and violent response.

Staff violated SYSC policy and professional standards by failing to employ the least amount of force necessary and failing to use other less restrictive behavioral interventions before using force. There were a number of less restrictive behavioral interventions the youth counselors could have used to control the situation and address and de-escalate J.D.'s behavior. At a minimum, they could have called a treatment coordinator (as staff did earlier that evening) or another counselor to deescalate J.D.'s behavior. Staff failed to document *any* specific attempts to deescalate J.D.'s behavior once he returned from Intake and before they restrained

[24] SYSC trains staff in "Aggression Management Techniques." Mr. Gardner employed a one-arm take-down, an SYSC-approved "Aggression Management Technique." DRC continues to have major concerns with SYSC's use of these techniques.

him. Instead of employing more therapeutic or non-violent interventions, it appears that staff's attempts to redirect J.D. to sit on his bed and stay away from his door only served to escalate the situation.

The use-of-force restraint was improperly executed and in a manner that both harmed J.D. and exposed him to the risk of serious injury or death. The restraint was employed in an extremely small space where it was highly likely that J.D.'s head would come into blunt contact with the furniture in the room. In fact, the evidence supports J.D.'s allegation that he hit his head on the desk during the restraint. Mr. Gardner admitted to not paying attention to J.D.'s head when executing the take-down. Mr. Leitner then dragged J.D. across the room while J.D. was still face-down. This resulted in an abrasion on his cheek, 2" in diameter.

J.D. was then held in a prone restraint for an unknown period of time. Staff failed to document how long he was held. There is enough evidence to support J.D.'s allegation that during the prone restraint, Mr. Gardner placed pressure on J.D.'s back and shoulders, thus using a greater amount of force than appropriate and exposing J.D. to further harm. Unless carried out properly so that undue pressure is not placed on the back of the person being restrained, prone restraint can result in positional asphyxiation.[25] Nurse Racine's progress notes indicate that in addition to a swollen cheek from a 2" abrasion, J.D. had a reddened area on his left upper chest area near left armpit and four superficial scratches on back ranging in size 4" to 2" in length. There is no evidence that staff immediately moved J.D. from the prone position to a sitting up position, as required by SYSC policy and professional standards.

Mr. Gardner and Mr. Leitner's actions prior to the incident caused the situation to escalate and caused J.D. to act out. They disregarded important information they had or should

[25] *See, e.g.*, Stephan Haimowitz, et al., Restraint and Seclusion: A Risk Management Guide, September 2006, National Technical Assistance Center for State Mental Health Planning, *available at* http://www.nasmhpd.org/general_files/publications/ntac_pubs/R-S%20RISK%20MGMT%2010-10-06.pdf.

have had about J.D. when disciplining him for behaviors that were directly related to his disabilities. They failed to document any specific attempts to deescalate J.D.'s behaivors once he returned from Intake and before they restrained him. Not only could the incident have been prevented, it appears from the evidence that staff consistently exacerbated the youth's disruptive behaviors that evening.[26] Not only were staff warned by J.D.'s GAL and JPPO that J.D. was upset that day, they also failed to exhibit or document that they were concerned for or considered J.D.'s specific needs and history of emotional challenges.

Finally, it appears that J.D.'s overall long-term treatment and intervention strategy at SYSC was not designed to address his behaviors through less restrictive more behaviorally positive means. If so, this incident and the restraint incident where staff fractured J.D.'s elbow could have been avoided.

VI. Additional Findings

A. SYSC's Response, Reporting & Investigation of the Alleged Incident

As discussed in detail below, the manner in which SYSC staff responded to, reported and investigated the allegation of staff abuse violated professional and legal standards and SYSC's own policy.

1) SYSC's Failure to De-Brief Incident

There was no documentation of any therapeutic interventions following the incident. SYSC staff did not de-brief the incident with J.D. and/or with other staff. There was also no evidence of a clinical review of the impact of the incident on the child's mental health in order to minimize the risk of needing to use such techniques again in the future. There was also no

[26] In completing this phase of the investigation, DRC has not made a determination about the sufficiency of the training, supervision and monitoring staff receive; which on the one hand could have prevented these actions and on the other hand could have had little or no bearing.

meaningful administrative review of the incident to prevent re-occurrence with J.D. or with other children.

SYSC did not have a policy or practice in place at the time of the incident requiring staff to de-brief with the child and/or with other staff.[27] De-briefing such an incident with youth, clinical, and administrative staff is critical to analyze what happened, to prevent re-occurrence, or to otherwise learn lessons from the incident. Staff's failure to de-brief with J.D. and/or with other staff is neglectful because it created a strong likelihood that such actions could reoccur.

SYSC and DJJS's failure to develop a policy requiring staff to de-brief the incident with the child constitutes a dereliction on the part of these agencies. Such a practice is widely accepted as standard and an essential component in preventing re-occurrence of behaviors by the child and reactions by staff. If a de-briefing had occurred following the restraint incident which resulted in J.D. fracturing his elbow, this most recent incident could potentially have been prevented.

2) Issues with SYSC's Reporting of the Alleged Incident

The first issue with SYSC's ***internal*** reporting of the alleged incident is that staff failed to follow SYSC's own internal reporting policies and procedures. On the evening of June 9, 2008, Nurse Racine completed and submitted an Incident Report Form documenting J.D.'s allegation and her observations. Mr. Gardner and Mr. Leitner also completed and submitted a different Incident Report. The following day, Nurse Racine completed another Incident Report Form at the request of John Duffy, Bureau Chief.

[27] SYSC recently developed Policy #C-003, effective 10/1/08, which now requires staff to de-brief at the end of the shift when a use of force or mechanical restraint incident occurs. The de-briefing is to be between the Unit House Leader or Juvenile Probation and Parole Supervisor, or designees and all staff involved in the incident. SYSC internal policy still does not require staff to de-brief with the child.

SYSC policy requires staff to complete a number of steps to document and internally report all incidents of mechanical and/or physical restraint use.[28] Staff are first required to complete an Incident Tracking Report in SYSC's electronic database. Secondly, they are required to complete a "Use of Mechanical Restraint Sheet" that is turned into "Operations". SYSC policy requires that all staff members involved in the incident submit a witness statement on the *same* Incident Tracking report. The third requirement is for the incident reports to be turned into the immediate supervisor, who then turns the report into the Bureau Chief of Residential Services and the Division Director.

Lastly, within 48 hours, all incident reports are required to be reviewed by a "Use of Mechanical and/or Physical Restraint Review Board", which is comprised of the Bureau Chief of Residential Services, the Bureau Chief of Administration, and the Chief of Operations. SYSC policy states that upon review, the board must then make a recommendation to the Director (or designee) on whether or not the staff member involved was in compliance with DJJS policy and procedures and what further action may be recommended, such as remedial training or disciplinary action. The board is also authorized to note any finding of policy failures and to make any recommendations thereof.

In this case, staff completed an Incident Report in SYSC's database, but failed to complete a Use of Mechanical Restraints Sheet. Staff also failed to include all witness statements on the same report. Mr. Gardner and Mr. Leitner did not include Nurse Racine's statement (that likely would have contained J.D.'s allegations) on their incident report. Because of staff's failure to complete a Use of Mechanical Restraint Sheet, the incident was not reviewed by the Use of Mechanical and/or Physical Restraint Review Board. Bureau Chief Duffy and Jim

[28] "Use of Mechanical and/or Physical Restraints". SYSC Policy #3-A-15.

Peace, Senior House Leader also failed to request that the staff involved complete the form and submit it to the review board.

Staff also failed to follow SYSC internal policy #1-C-03, which requires SYSC to report suspected abuse or neglect of a resident to the Director of DJJS or designee and the Director of Human Resources (DHHS). There is no evidence that this was done in this case.

SYSC's reporting policy itself is flawed because it prevents certain allegations of abuse and neglect from being ***externally*** reported. The policy gives SYSC administration the discretion of whether or not to report an allegation of abuse or neglect after they have made their own determination and/or conducted their own investigation. This is a violation of RSA 169-C:29. A second flaw is that the policy does not specifically reference to RSA 169-C:37, which authorizes allegations of institutional abuse and neglect at SYSC to be externally reported to DOJ or HHS.

Additionally, with respect to ***external*** reporting of this particular incident, staff members failed to report the incident to the Division for Children, Youth & Families (DCYF), even though J.D. reported the alleged staff abuse to a number of staff members. The incident was eventually reported to DCYF by J.D.'s GAL. New Hampshire's Child Protection Act requires that certain individuals must report to DCYF if they have reason to suspect that a child has been abused or neglected.[29] *See* RSA 169-C:29. Mandatory reporters include, among others, law enforcement officers and registered nurses. A number of SYSC staff believed or had reason to believe that abuse had occurred in this particular incident, thus meeting the standard for mandatory reporting

[29] Recognizing the seriousness of child abuse and neglect, DCYF encourages individuals to report suspected abuse or neglect even if they are in doubt. *See* http://www.dhhs.state.nh.us/DHHS/BCP/report-abuse.htm.

under RSA 169-C:29. SYSC staff violated this provision of the Child Protection Act by not reporting J.D.'s allegations to DCYF.

Staff at SYSC also failed to report the incident to either DOJ or DHHS, pursuant to RSA 169-C:37. The Child Protection Act specifically permits such reports of institutional abuse and neglect under RSA 169-C:37. Staff failure to report to DOJ and/or to DHHS is a result of SYSC or DJJS's failure to develop a clear reporting policy for reporting abuse or neglect under RSA 169-C:37. It is also a result of DHHS and/or DOJ's failure to develop regulations, protocols and/or a mechanism for reporting institutional abuse and neglect pursuant to RSA 169-C:37.

3) Issues with SYSC's Investigation

Mr. Duffy and Jim Peace, Senior House Leader completed an internal "Incident Investigation", resulting in a report dated July 3, 2008. It is clear that Mr. Duffy reviewed 1) an email statement from Brian Bedard; 2) the three different incident reports; and 4) photographs taken of J.D.'s face and room. It is unclear whether Mr. Duffy conducted any actual interviews or reviewed any documentation of Nurse Racine's medical assessment. Mr. Duffy did not document any of his subsequent actions once he received the complaint of staff abuse.

Mr. Duffy's "Incident Investigation" reviewed and defined J.D.'s allegations as: "YC Gardner tried to bang resident's head on the wall in his room"; "YC Gardner grabbed resident's shoulder and threw him between his desk and bed"; "YC Gardner kicked resident in the face" and; "YC Gardner kneed resident in the head". Yet, Mr. Duffy determined that all the allegations were unfounded and concluded in one sentence that there was no evidence, other than the resident allegation, of an inappropriate restraint. It is our understanding that J.D. was actually disciplined for his behavior that evening.

We find that SYSC's internal incident review and investigation were deficient. Mr. Duffy and Mr. Peace failed to follow internal policy and basic review and investigation standards and practices in at least eight ways.

First, during SYSC's internal investigation, it appears that SYSC administration give no consideration to ensuring that staff did not have any contact with the residents or at least the youth involved, standard practice when there is an allegation of abuse.

Second, staff failed to follow internal SYSC policy as discussed above. Instead of reporting the incident to the restraint review board, Mr. Duffy and Mr. Peace conducted their own investigation of specific allegations made by J.D..

Third, Mr. Duffy and Mr. Pearce as part of their investigation, failed to gather and review all the relevant records and documents that had a bearing on the allegation. The report failed to mention that they reviewed Nurse Racine's medical assessment or any other medical progress notes.

Fourth, Mr. Duffy and Mr. Peace failed to interview all the relevant individuals involved in the incident. There is no documentation that they interviewed any other residents who could have been potential witnesses. There is also no evidence that they interviewed Nurse Racine or any other staff members besides Mr. Gardner and Mr. Leitner. Interviewing these individuals or at least exploring whether anyone else had relevant information should have been done.

Fifth, Mr. Duffy and Mr. Peace's report summarizing their findings failed to include many significant facts. They left out the fact that J.D. reported the allegations of staff abuse to Nurse Racine. Instead, they glossed over this fact and indicated that J.D. "recounted to the nurse the events that precipitated the restraint, admitting that he was taunting YC Gardner, calling him names and being disruptive by banging on his door and wall." The report makes no mention or

conducts no analysis of Nurse Racine's interactions with and comments made by Ms. Mirabella and Ms. Clark-Smith. The report also failed to mention who J.D. reported the incident to and the fact that all his reports were consistent.

Sixth, Mr. Duffy and Mr. Peace failed to conduct any meaningful analysis of the appropriateness of the actual restraints. The report failed to come to any conclusion regarding the appropriateness of the mechanical restraint and concluded in one sentence (without analysis) that "YC Gardner and YC Leitner report an appropriate one-arm take down" and "no evidence other then resident allegation of an inappropriate restraint." The report made no mention of SYSC policy and contained no analysis of whether YC's followed policy.

Seventh, the report was highly myopic. Mr. Duffy and Mr. Pearce inappropriately limited the investigation report to individual allegations rather than looking at the situation as a whole. They failed to discuss potential triggers to the restraint, possible staff escalation, J.D.'s mental health situation and how the situation could have been avoided.

Eighth Mr. Duffy and Mr. Pearce merely took Mr. Gardner and Mr. Leitner's characterization of the incident at face value and gave no weight to the child's allegations. They essentially failed to conduct any independent analysis of the relevant evidence.

A. SYSC's Unmonitored, Unregulated and Unaccredited Status

1) External Reporting

As discussed above, there was no report of abuse or neglect made to DCYF by any SYSC staff regarding this particular incident. The incident warranted reporting by SYSC staff. At least eight staff were aware of the incident. Their failure to report constituted a violation of RSA 169-C:29. When the matter was reported to DCYF by J.D.'s GAL, DCYF initiated an investigation which as of this date has not been completed. More recently, it is our understanding that DCYF

did not actually complete their investigation nor did they generate a report. Instead, the investigation was transferred to the Attorney General's Office of DOJ. DRC, as part of the above referenced wider investigation, is examining to what extent SYSC staff report possible incidents of abuse and neglect to DCYF and the extent to which DCYF then initiates investigations. We are also reviewing the reason why DCYF apparently stopped their investigation of this particular incident and why the Attorney General's Office took it over and/or initiated a new one.

2) Reviews, Monitoring or Accreditation

SYSC is a state-owned and operated facility; operated in accordance with RSA 621 and RSA 621-A. With the exception of the educational program, none of the facilities or programs at SYSC are licensed, certified, regulated, monitored or accredited by external agencies to ensure conditions, services and programs at SYSC meet safety, treatment, health and welfare standards. This is particularly important because the facility houses individuals with disabilities, particularly children with mental illness who (a) need treatment and (b) are susceptible to further harm from suboptimal environmental conditions or conduct.

3) Bylaws

Although SYSC is required under RSA 621:7, SYSC does not maintain a set of bylaws for the governance and management of SYSC. SYSC operates under its own internal policies and procedures that are not readily available to the public and did not go through the public rule-making process.

VII. Recommendations

National attention has recently been paid to the troubling conditions of confinement for youths in juvenile detention centers.[30] Youth in detention with mental illness are particularly vulnerable to the negative consequences of various conditions of confinement.

Under its federal authority, DRC is continuing its investigation on a broader scope into conditions of confinement for children with mental illness confined to SYSC. More specifically we are reviewing SYSC's system for addressing allegations of staff abuse and neglect, and SYSC's behavior management system, including the use of discipline, use of force, restraints, and seclusion.

While more systemic recommendations may arise from the broader investigation, DRC determined that the investigation of the incident(s) involving J.D. and our resultant recommendations should not be delayed in this report because of the immediate health, welfare and safety needs of J.D. and other residents at SYSC. Our recommendations fall into three separate categories: 1) specific recommendations to SYSC and DJJS regarding this particular reported incident of staff abuse and neglect; 2) general recommendations to SYSC and DJJS; and 3) recommendations to DHHS.

A. Recommendations to DJJS & SYSC Specific to this Case

5) Develop appropriate concrete, specific, informed and behaviorally positive strategies, to therapeutically respond to J.D.'s behavior challenges;
6) Utilize an independent, qualified psychologist or other behavioral specialist to help develop and oversee the plan and approach;

[30] Sue Burell, Youth Law Center. "Improving Conditions of Confinement in Secure Juvenile Detention Centers." A project of the Annie E. Casey Foundation. Pg. 10 and 11.

7) Provide the youth a written apology for the harm he suffered while at SYSC due to failure of SYSC staff to follow policies, to provide a physically and emotionally safe place for him, and to provide an effective oversight of his stay there; and

8) Take the appropriate disciplinary action against Mr. Gardner and Mr. Leitner for their actions.

B. General Recommendations to DJJS & SYSC

12) As use of force restraint and containment is viewed as the result of a treatment failure, not a treatment intervention, DJJS should conduct a ***rigorous analysis of their current behavior management system*** to ensure it is in line with professional standards. This should be overseen by an independent organization such as JDAI. At a minimum DJJS should review their current behavior management system, however we also strongly suggest that an organization such as JDAI review all of DJJS's policies and procedures as related to SYSC;

13) As there is considerable amount of literature on the life-threatening dangers of prone restraints, including numerous cases of asphyxiation and cardiac arrest,[31] SYSC should ***immediately discontinue the use of prone restraint***.

14) Currently, SYSC policy permits staff to carry out physical interventions using "Joint Compliance Techniques" which "are designed to cause pain to a joint, which results in compliance;"[32] SYSC should ***immediately discontinue the use of pain compliance techniques***.[33]

---

[31] *See, e.g.*, Stephan Haimowitz, et al., Restraint and Seclusion: A Risk Management Guide, September 2006, National Technical Assistance Center for State Mental Health Planning, *available at* http://www.nasmhpd.org/general_files/publications/ntac_pubs/R-S%20RISK%20MGMT%2010-10-06.pdf.

[32] SYSC Policy#C-003.

15) Establish and implement specific procedures to ensure ***staff*** report abuse and neglect pursuant RSA 169-C:37 and provide training to staff on how to report institutional abuse and neglect;

16) Establish and implement specific procedures to advise ***residents*** that they may report abuse and neglect pursuant RSA 169-C:37 and how to report institutional abuse and neglect;

17) Initiate and continue training of all staff on their mandatory abuse and neglect responsibilities;

18) Ensure that all staff receive training on appropriate management of the behavior of children with mental illness;

19) Ensure that counselors are available at all times;

20) Expand data collection on behavioral incidents to better track the occurrence of behavioral incidents (and eventually reduce restraint and isolation and improve staff intervention in behavioral incidents);

21) Institute a more extensive monitoring process of incidents of restraint and isolation, including regular restraint reviews involving an appropriately qualified consulting psychiatrist or psychologist who can review incident reports as a way to improve staff intervention in behavioral incidents;

22) Provide DRC a written plan with timelines to implement the recommendations above.

C. Recommendations to DHHS

3) Promulgate rules using professional standards to govern the administration and oversight of SYSC;

---

[33] Pain compliance techniques are different from defensive physical force use that may be needed by staff in emergency situations.

4) Promulgate rules consistent with DHHS's authority to investigate reports of institutional abuse and neglect and to take the appropriate action for the protection of children pursuant to RSA 169-C:37 and RSA 169-C:3-a(III).[34]

[34] Rule-making pursuant to this section is permitted under RSA 169-C:37 and required under RSA 169-C:3-a(III). RSA 169-C:37 provides that "[e]ither the department of justice or the commissioner of the department or both **may** adopt rules consistent with this authority to investigate such reports and take appropriate action for the protection of children." (Emphasis added). RSA 169-C:3-a(III) provides that "[t]he commissioner of the department of health and human services **shall** adopt rules under RSA 541-A relative to…[t]he authority to investigate reports of institutional abuse or neglect under RSA 169-C:37." (Emphasis added).

Addendum

On December 15, 2008, DRC became aware that the Attorney General's Office of the DOJ had in fact investigated the incident discussed in the attached report. Our office immediately requested the Attorney General's investigation report, along with any other materials involved in their investigation of the incident, including all materials from DCYF. Nearly one month after our request, and one week after the attached report was completed and submitted to a number of parties, the Attorney General's office forwarded materials to our office on January 14, 2009.

In the attached report we stated, on pages 37 and 38, that it was our understanding that "DCYF did not actually complete their investigation nor did they generate a report." The materials received from the Attorney General's office show that DCYF actually did conduct an investigation and generate a report. The materials also revealed that it was DCYF, not staff from SYSC who referred the incident to the DOJ. DCYF made the referral to DOJ on June 18, 2008 and DOJ in turn authorized DCYF to complete the investigation. It appears that DCYF completed the report and forwarded the results to the Attorney General's office on December 11, 2008, nearly six months after the incident was first reported to the State.

In the above-mentioned materials, DRC also received from the Attorney General's office a document entitled "Use of Force/Mechanical Restraint Report" which indicated that the Use of Force/Mechanical Restraint Panel reviewed the incident involved in the attached report on 6/24/08 and found "Staff Member in compliance with Policy." On page 33 of the attached report, DRC found that "the incident was not reviewed by the Use of Mechanical and/or Physical Restraint Review Board. Even though we had requested all internal documentation of the incident when we conducted our investigation at the facility in June, 2008, DRC was not given a copy of this document. Regardless, it appears from the document that there was still no meaningful review of the incident. The Panel made their determination at the bottom of the form, but failed to complete the requirements of the form, including the "Reason for Mechanical Restraints/Handcuffs"; "Reason for Use of Force" and whether the incident was de-briefed.