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JEFFREY A. MEYERS
COMMISSIONER

May 15, 2018

Karen L. Rosenberg, Esquire
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Disability Rights Center – NH
64 North Main Street, Ste. 2
Concord, NH 03301-4913

Re: DCYF's Response to The Disabilities Rights Center's May 8, 2018 Report Regarding Unlawful Use of Physical Restraint at The Sununu Youth Services Center

Dear Attorneys Rosenberg and Milne:

Attached please find the response of the New Hampshire Department of Health and Human Services (DHHS) and the New Hampshire Attorney General's Office to The Disabilities Rights Center's (DRC) May 8, 2018 report, entitled "Unlawful Use of Physical Restraint at Sununu Youth Services Center" (DRC's report).

DRC's report contains numerous factual errors, unsupported conclusions, and incorrect statements of law. While the Sununu Youth Services Center (SYSC) agrees on the goal of minimizing the use of restraint in all settings, children are not being abused and neglected at SYSC through the improper and unlawful use of restraints. That DRC corrected some of the errors identified in the draft report but did not wait for additional corrections before issuing the final report indicates DRC was more interested in rushing out its report than having to reconsider the inaccuracies and omissions that it now contains. Overall, DRC's allegations of abuse of youth by SYSC employees are unfounded and irresponsible.

DRC is being provided with an unredacted copy of SYSC's response. In order to provide the public with an accurate explanation of the use of restraints at SYSC, DHHS and the Attorney General's Office are also providing a slightly redacted report for the public to review. Information that is protected by specific confidentiality laws has been redacted.

The Department is committed to providing a safe and therapeutic environment for the State's most at risk youth. We vehemently disagree with DRC's report, which appears to have been created with the sole purpose of making a finding of abuse against SYSC staff in order to

further DRC's objectives. The lack of objectivity and fairness in DRC's report creates obstacles to the State's goal of working with DRC collaboratively to identify and improve the services it provides to New Hampshire's youth.

Sincerely,

Jeffrey A. Meyers
Commissioner

Enclosure

cc: Stephanie Patrick, Executive Director, Disability Rights Center – NH
Governor Christopher T. Sununu
President Chuck Morse
Speaker Gene Chandler
Attorney General Gordon MacDonald

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Re: DCYF's Response To The Disabilities Rights Center's May 8, 2018 Report Regarding Unlawful Use Of Physical Restraint At The Sununu Youth Services Center

Dear Attorneys Rosenberg and Milne,

The State fully supports the goal of reducing the use of restraint in all settings, particularly at the Sununu Youth Services Center (SYSC). We believe that restraint can be avoided through the development of appropriate program models and that it should only be used where necessary for the safety of the youth involved. To that end, SYSC began to utilize Therapeutic Crisis Intervention (TCI) in 2015 to foster an environment where non-coercive, non-aggressive environmental and behavioral strategies and interventions are used to de-escalate crisis situations and promote emotional self-regulation and growth. With a goal of further improvement, SYSC is now in process of implementing Trust-Based Relational Intervention (TBRI). SYSC leaders were recently certified as trainers in TBRI and will begin training the SYSC staff next month with a goal of implementing the practice by the end of 2018. As an organization committed to learning and improvement, SYSC intends to monitor the effectiveness of these interventions and continue to adjust our program accordingly.

While we agree on the goal of minimizing the use of restraint in all settings, The Disabilities Rights Center's (DRC) May 8, 2018 report, entitled "Unlawful Use of Physical Restraint at Sununu Youth Services Center" (DRC's report), **contains numerous factual errors, unsupported conclusions, and incorrect statements of law.** Children are not being abused and neglected at SYSC through the improper and unlawful use of restraints. Overall, DRC's allegations of abuse of youth by SYSC employees are unfounded and irresponsible. Further, in the misleading context of DRC's May 8th report, the use of employees' names places an unnecessary and unfair burden on them as individuals and professionals and potentially creates a personal safety risk.

Unfortunately, DRC's approach to this serious issue serves only to enflame a sensitive subject rather than advance our work toward a common goal. Accordingly, this response will address the **numerous factual errors, unsupported conclusions, and incorrect statements of law in order to clarify the public record on this matter**.

1. The State Cooperated Fully with DRC to Provide Information for its Investigation

DRC's report inaccurately states that SYSC has not cooperated with DRC's investigation. SYSC cooperated fully with DRC's investigation. SYSC provided DRC with extensive records and access to the facility. DRC was given unfettered access to the files of more than 40 residents and obtained complete copies of these files. Additionally, SYSC produced to DRC more than 400 pages from the SYSC electronic records system, documents which DRC selected after SYSC provided DRC attorneys with an explanation of the electronic records system. SYSC also produced numerous policies and procedures as requested by DRC. Similarly, DRC received the Department of Justice's (DOJ) report regarding the incident involving the youth identified by the pseudonym "Zach,"[1] which included the report done by the Special Investigations Unit (SIU) under the direction of DOJ. That report included the separate New Hampshire State Police investigation report of that same incident. DRC was also provided with three flash drives containing dozens of videos recordings of incidents involving youth restraint. Finally, SYSC staff and residents were made available to DRC for interviews upon request throughout.

While the State fully cooperated with DRC to ensure that it had accurate and complete information about the use of restraints and the specific incidents reviewed, DRC from the beginning showed little interest in providing the State with a meaningful opportunity to respond. DRC initially provided the Attorney General's office a 9-page partial draft report, on April 16, 2018, after 6:00 PM, and it gave the State 3 ½ days to respond. The State and DRC subsequently agreed that the State would have 2 weeks to respond. On May 3, 2018, Senior Assistant Attorney General Rebecca Ross met with Attorney Milne and, after providing him with information showing some of the inaccuracies in DRC's draft report, requested a few additional days to complete and provide the State's full response to the DRC draft report. She then sent a follow up email requesting the additional days. DRC did not respond. Instead, without waiting the additional days for the State's response to its draft, DRC issued its final report. DRC did so even after modifying its draft report to correct some of the inaccuracies that Attorney Ross pointed out on May 3, 2018. DRC's statement, on pages 14-15 of its report, "[a]s of the publication of this report, on May 8, 2018, DRC has not received any correspondence from Director Serafin or his legal counsel with evidence of additional factual inaccuracies, critical omissions or legal issues," is misleading to the public. DRC's public comments stating that the State did not respond are simply untrue. It is evident that DRC was more interested in rushing out its report than having to reconsider the inaccuracies and omissions that it now contains.

An important example of these inaccurate statements relates to "Personal Safety Plans." DRC's report states, on page 15, that "[o]n May 3, 2018, DRC was informed that SYSC

[1] In order to protect the youth's confidentiality, SYSC uses the pseudonym "Zach."

possessed, but had not provided, documents that DRC had requested on November 6, 2017." DRC learned about this issue through the face-to-face meeting with Attorney Ross. With regard to the SYSC policies pertaining to use of restraints, Policy No. 2131, Proactive Safety Planning, requires a Personal Safety Plan (Plan) to be completed "as soon as possible not to exceed 5 days" after a youth's admission to SYSC. The Plans are being developed for youth at SYSC and are being used every day by staff.

However, based on the State's review of DRC's draft report, SYSC realized that a copy of the Plan has not been filed in each youth's paper file. Although staff are properly electronically uploading the Plans to CourtStream, SYSC's case record system, in accordance with the policy, SYSC determined that the Plans have not been printing properly. Thus, when SYSC printed the requested files for DRC, the Plans were not included. This was an oversight which was only identified when SYSC received DRC's draft report. Attorney Ross specifically requested a meeting with Attorney Milne on May 3, 2018, in order to provide this information to DRC. In the case of Zach, DRC was provided with his Personal Safety Plan months ago when it was provided with the DOJ's Investigation Report. In order to rectify this situation in the future, DCYF has requested information technology support to correct this issue. SYSC provided DRC with 16 of the 18 requested Plans on May 11, 2018.

The DRC report also claims that SYSC Director Brady Serafin was not providing reports regarding the use of restraints in accordance with the law. **This is not accurate.** Director Serafin had previously informed DRC Policy Director Michael Skibbie that DRC received a copy of the report and the investigation/review reports when the process was complete. Consistent with that understanding, DRC received both the report of the restraint and the investigation/review relating to Zach upon completion of the reviews on October 16, 2017.

RSA 126-U:7 states that a copy of the information regarding restraint of, seclusion of, or physical contact with a youth shall be provided to the youth's parents or guardians as "soon as practicable . . . and in no event later than . . . the end of the business day." RSA 126-U:10, I provides that in the case of serious injury or death of a child subject to restraint or seclusion, the facility shall also notify the Commissioner of DHHS, the Attorney General, and the State's federally-designated protection and advocacy agency. Neither RSA 126-U:7 nor RSA 126-U:10 include any deadline for when DRC is to receive the report. As a result, Director Serafin's process was reasonable and is supported by the Annual Notice of Responsibility to Report Incidences of Serious Injury or Death During a Restraint or Seclusion issued by DHHS. *See* Attachment A.

The Legislature included many deadlines in RSA 126-U but it did not add a specific deadline regarding notifying DRC. SYSC will establish a more specific reporting deadline for the initial reports to DRC. Additionally, following the above-referenced conversation between Directors Serafin and Skibbie, SYSC performed a records review from 2010 to 2017 to determine whether there were any reports of serious injury that were not reported to DRC. **There were none.** Further, there were no serious injuries, outside of those included in DRC's report, that have occurred since 2010.

2. The Role and Function of the Sununu Youth Services Center

SYSC is a restrictive placement for either detained or committed youth – for which a court has found by "clear and convincing evidence" that "commitment is necessary to protect the safety of the minor or of the community …." RSA 169-B:19, I (j). In enacting RSA 169-B, the Legislature plainly recognized that a range of out of home placements for justice-involved youth was necessary and that a spectrum of care must necessarily involve secure placements for youth who are a danger to themselves and to the community.

When a youth is found delinquent by a court, the court may order the least restrictive disposition, "which the court finds the most appropriate." While DRC focuses on ensuring that every placement be the least restrictive, its report consciously overlooks the court's obligation to ensure that the disposition be the most appropriate. Restraint of a youth is never a preferred option in responding to escalating behavior. But SYSC staff must consider a youth's criminal and behavioral history. To do otherwise would diminish the risks to the residents, SYSC staff, and those visiting SYSC that must be considered when a youth's behavior is escalating.

In comments attributed to DRC Attorney Andrew Milne in connection with the release of the DRC report, DRC will be recommending that the court stop placements of youth to SYSC. *See* Union Leader, May 9, 2018. Not only would that result be inconsistent with current law, but it would endanger the community which is not equipped to rehabilitate the youth who are otherwise committed to SYSC. While the Legislature has already directed more youth into community setting with additional resources, the community providers are already struggling to adjust their service capacity to accept and treat those youth who previously would have gone to SYSC. If SYSC can no longer accept any youth, the juvenile justice system will be in crisis.

DRC's draft report also made a representation that the majority of youth are placed at SYSC for "non-violent" offenses. This representation was removed from the final report, but is clearly part of DRC's mindset, as the focus of DRC's report, at pages 5-6, is on the number of youth in the juvenile justice system who have disabilities and/or mental illness. While the State agrees that many of the youth at SYSC have mental illness and/or disabilities, they also have behavioral and criminal histories that are the reason for their detention or commitment at SYSC. SYSC houses and treats a significant population of youth with serious and dangerous behaviors.

The DRC report, on page 5, states that "youth are regularly transferred to the CSU for behaviors unrelated to personal safety." The State disagrees with this conclusory assertion. SYSC appropriately transfers youth to the Crisis Services Unit (CSU) within SYSC for behaviors related to personal safety. When youth with a history of physical misconduct are deregulating, escalating, and refusing to follow directions that are given to address safety concerns, it is reasonable and necessary for staff to utilize a transfer to the CSU to ensure safety, if, in their assessment of the youth, there is a substantial and imminent risk of serious bodily harm to the youth or others. Knowing the behavioral information for each youth is critical to

assessing the level of risk when a youth's behavior is deregulating. DRC's report fails to acknowledge the staff's personal knowledge of the youth and their behavioral histories gained from working with the youth and their clinical teams.

DRC's representation, on page 5 of the report, that youth in CSU "are typically required to spend most of the day alone in their rooms" and do not attend school or groups **is inaccurate.** Youth are rarely in CSU for more than one or two days. They are assessed daily to determine whether they are ready to safely return to their Units. If a youth is not demonstrating safety, he or she may not be able to attend school or other activities. However, if a youth is safe, then the youth in CSU can attend school and spend much of his/her time in the common areas, not in his/her room. Youth are transferred to CSU for safety reasons and limiting their access to items that could be used to injure a youth is a necessary component of providing a safe environment.

3. SYSC's Use of Restraints is Lawful and Limited to Appropriate Circumstances

SYSC agrees with DRC's conclusion, on page 6, that restraining a youth is "dangerous and should be avoided whenever possible." SYSC operates under this philosophy. However, there are times when youth, through their own actions, pose an imminent and serious risk of being dangerous to themselves or others, and lawful restraints must be used.

DRC's report, on page 17, **incorrectly asserts** that "[p]rone, face-down restraint" is "a dangerous technique, in violation of both New Hampshire law and its own policy prohibiting the use of certain dangerous restraint techniques including holding youth in a prone position." Neither RSA 126-U nor SYSC Policy No. 2083 prohibit prone, face-down restraints. RSA 126-U:4 prohibits the use of dangerous restraint techniques:

> No school or facility shall use or threaten to use any of the following restraint and behavior control techniques:
>
> I. Any physical restraint or containment technique that:
>
> (a) Obstructs a child's respiratory airway or impairs the child's breathing or respiratory capacity or restricts the movement required for normal breathing;
>
> (b) Places pressure or weight on, or causes the compression of, the chest, lungs, sternum, diaphragm, back, or abdomen of a child;
>
> (c) Obstructs the circulation of blood;
>
> (d) Involves pushing on or into the child's mouth, nose, eyes, or any part of the face or involves covering the face or body with anything, including soft objects such as pillows, blankets, or washcloths; or
>
> (e) Endangers a child's life or significantly exacerbates a child's medical condition.
>
> II. The intentional infliction of pain, including the use of pain inducement to obtain compliance.
>
> III. The intentional release of noxious, toxic, caustic, or otherwise unpleasant substances near a child for the purpose of controlling or modifying the behavior of or punishing the child.

IV. Any technique that unnecessarily subjects the child to ridicule, humiliation, or emotional trauma.

During the development of RSA 126-U in 2010, the Legislature heard testimony and saw demonstrations related to different restraint positions. In fact, there were demonstrations showing that a prone position restraint for a short period of time did not create chest compression or back pressure. As a result, the above-cited to language in RSA 126-U:4 was enacted and does not restrict the use of prone restraint techniques.

SYSC Policy No. 2083 states that youth "shall not be left in a prone position due to the possibility of positional asphyxia." The policy also states that any youth who has been in a restraint must have his/her well being assessed within 24 hours.

With respect to DRC's finding that staff "routinely uses prone, face-down restraint," on page 17, we strongly disagree with DRC's characterization of the staff's actions as "routine" or that the staff's action in these cases are in violation of the law and SYSC policy. The use of the term "routine" is misleading. DRC cites only three examples in a multi-year period in which children were in a prone position. Two of these instances lasted less than 30 seconds and one was for approximately 2 – 3 minutes. These limited examples cannot support a conclusion that this is a "routinely" or "regularly" implemented action under any definition. The Department of Health and Human Service's 2017 Annual Report Regarding Child Restraint Practices Pursuant To RSA 126-U also does not support this finding. During the period of November 1, 2016, through October 31, 2017, there were 76 reportable restraints at the facility when the average census was 58.94 youth. *See* Attachment B. During that period, the DHHS Office of the Ombudsman received one complaint regarding a restraint at SYSC and DRC's report identifies three restraints that it questions.

DRC's report, on page 17 and elsewhere, references that SYSC staff are violating New Hampshire law when they use restraints "to remove a disruptive youth who is unwilling to leave an area voluntarily." These statements suggest that SYSC staff are not permitted "to remove a disruptive youth who is unwilling to leave an area voluntarily." **That is not correct** under New Hampshire law. In fact, in accordance with RSA 126:U:7:

> VI. The notification and record-keeping requirements of paragraphs IV and V shall not apply in the following circumstances:
>
> (a) When a child is escorted from an area by way of holding of the hand, wrist, arm, shoulder, or back to induce the child to walk to a safe location. However, if the child is actively combative, assaultive, or self-injurious while being escorted, the requirements of paragraphs IV and V shall apply.
>
> (b) When actions are taken such as separating children from each other, inducing a child to stand, or otherwise physically preparing a child to be escorted.
>
> (c) When the contact with the child is incidental or minor, such as for the purpose of gaining a misbehaving child's attention. However, blocking of a blow, forcible release from a grasp, or other significant and intentional physical contact with a disruptive or assaultive child shall be subject to the requirements.

(d) When an incident is subject to the requirements of paragraphs I-III.

Accordingly, removal of a disruptive youth, which is often referred to as an escort, is permitted under New Hampshire law and is necessary to maintain safety in SYSC. DRC's assertion to the contrary is not only **incorrect based on the law**, but improperly communicates to other providers across the state that the often necessary option of an escort is unavailable when dealing with disruptive youth. Although some of the restraint reports at SYSC may not include all of the reasons for the restraints, this missing documentation does not mean that the restraints violate New Hampshire law or equate to abuse under the PAIMI Act.

4. Two Separate State Investigations Found That Zach's Restraint Was Appropriate

Pursuant to RSA 169-C:37, the DOJ is responsible for investigating reports of abuse and neglect in state facilities. Such investigations are conducted by DHHS's Special Investigations Unit under the direction of DOJ. The DOJ/SIU investigation was begun on January 5, 2017, the SIU investigation was completed on October 12, 2017, and the DOJ report was completed on October 16, 2017. The DOJ/SIU report concluded that the allegations of abuse and neglect were unfounded.

The DOJ/SIU investigation occurred over several months and included the findings made by the State Police. The DOJ/SIU investigation report found that "[t]he incident that did result in injury to the youth occurred accidentally during a restraint that was performed per policy." State Police's investigation involved a review of the physical and documentary evidence as well as interviews with six witnesses by investigators from New Hampshire State Police. State Police have jurisdiction because the injury occurred on State property. State Police, through Detective Kelly Healey, determined, on January 20, 2017, that no criminal conduct had occurred. "It is the determination this case does not meet the standard of a criminal offenses and the restraint was conducted for the safety of all parties involved (not as an intentional act of violence). Any and all contact with ZACH by MR. GILBERT and MR. ARSENAULT was within the context of a resident restain[t] (due to that resident being noncompliant and needing to be moved to a secure location for that resident's safety [as] well as the safety of others." State Police Report.

5. Issues Specific To Zach

SYSC will use the complete record that DRC had in its possession when responding to the allegations relating to Zach. **The DRC report failed to do so.** It ignored virtually all of the testimonial and documentary evidence available from the two State investigations that were done regarding the December 29, 2016 incident relating to Zach. DRC has selectively chosen certain information to cite to in its report. For example, DRC specifically criticizes the lack of audio recording available, but choses to not report on any of the statements made by staff and youth residents regarding what Zach was doing or saying during the incident. This cherry-picking of information leads to an inaccurate and misleading report of the incident involving Zach.

On December 29, 2016, Zach, a 5foot, 9inch tall, 193 pound, 14-year-old had been detained at SYSC because he had physically assaulted his grandmother who was his caregiver. DRC's draft report stated that, upon admission, Zach and his mother reported Zach's emotional and behavioral challenges to the staff. However, after the May 3 conversation with Attorney Ross, DRC changed the inaccurate statement in its draft report so that statement is not in the final report. DRC report, Page 15. SYSC has no record of Zach's mother being present when he was admitted to SYSC. Based on the contact log, it appears that Zach's mother was contacted by phone on the date of admission, a voicemail was left for her, and she was contacted again by SYSC staff the next day. She did not visit in person until nine days later on December 24, 2016. Additionally, SYSC has the Resident Personal Safety Plan showing the discussion with Zach, on December 18, 2016, regarding his emotional and behavioral challenges. In it, Zach reported that effective strategies for him to deal with conflict and stress include both being alone and being with people, depending on the circumstances. Zach also self-reported his history of physical aggression, yelling/screaming, punching walls, and throwing objects. When asked by staff as part of his Plan what positive behaviors staff could use to help him, his response was "unsure." SYSC correctly followed SYSC Policy No. 2131 and created Zach's Plan with him.

Further, in DRC's report, it provided all of the information regarding the mental health and behavioral health issues of the youth whose files were reviewed. However, nowhere in DRC's report is there information on the behavioral patterns or the previous criminal histories of these youth. This information is important when reviewing the actions of the youth, in determining the level of risk they pose, and determining whether they will act in a manner that poses a substantial and imminent risk of serious bodily harm to themselves or others. SYSC cannot safely ignore the behavioral patterns of the youths' previous histories. For example, SYSC believes that Zach's prior behavioral history is critical to his behavior management. The Division for Children, Youth and Families' records show that Zach's offense history demonstrates a history of physical aggression including the following:

Knowing this information is critical to assessing the level of risk when a youth's behavior is deregulating. In light of Zach's history of aggressive behavior, including the fact that he was at SYSC on December 29, 2017, because he physically assaulted his grandmother, it was proper for staff to reasonably conclude that his threatening behavior and verbal threats posed an imminent risk of serious harm to himself and others.

DRC asserts that Zach was moved to the CSU "as a consequence for disobeying an order to go to his room" in H Unit. **This statement is incomplete and misleading.** On December 29, 2017, Zach was transferred to the CSU for disobeying a Youth Counselor's (YC) order and

demonstrating unsafe behaviors. Zach self-reported to the Special Investigations Unit (SIU) investigator and New Hampshire State Trooper Detective Kelly Healey that the reason he was in CSU was for "ripping up a book and demonstrating unsafe behavior" – a critical detail omitted in DRC's report. Further, DRC failed to consider Zach's history of unsafe behavior including that just three days prior, Zach was seen by medical for reportedly punching a wall. Transferring Zach to CSU on December 29, 2017, was appropriate and lawful in light of SYSC staff's determination that this transfer was necessary for Zach's safety.

While at the CSU on December 29, 2016, at 3:28 pm, Zach started calling out to staff wanting to talk to a particular staff member, Supervisor Joel White, about his transfer to the CSU. Zach repeatedly attempted to exit his room without permission and was told by staff to return to his room. While DRC states that Zach "stood just outside his room, for a minute or two, while holding the door open," page 11, DRC fails to acknowledge any of the statements provided by the other youth residents interviewed by State Police and SIU who indicate Zach's behavior was escalating. For example, (youth resident 1) stated that Zach "was acting up" and "banging on his door, getting out of his room and posturing to staff," being "annoying and banging on the door and making loud noises" (youth resident 2), and Zach was standing in his doorway with the door opened and when SYSC staff members told him to shut the door, Zach said "no" (youth resident 3). Even Zach himself admitted to Detective Healey and the SIU investigator that he was "banging on his door" because he was really "upset." Instead of reporting this critical information regarding Zach's escalating behaviors, DRC states in its report, at page 11, that "[d]ue to lack of sound and quality of the video display, it is difficult to tell whether [Zach] and staff spoke during these instances." Because the witness statements are not conflicting, but rather consistent in stating that Zach was verbally noncompliant and engaging in challenging behavior, DRC's assertion serves no purpose other than to downplay Zach's actions. With these material omissions, **DRC fails to provide an objective perspective of the incident**.

With respect to the first restraint, when Zach tried to speak with Joel White, Supervisor White responded to Zach's request by saying that he would "see [Zach] later." Zach did not accept this answer and tried to leave his room. Nowhere, in any of the investigative reports or witness statements that Zach gave after the incident did Zach report that he "knocked on his door and asked to leave his room. Not hearing a response from staff, [Zach] opened the door to his room, and repeated his request for permission to leave his room." DRC Report, page 11. After Zach left his room, YC Gilibert attempted to guide Zach back into his room. YC Gilibert's use of a restraint was warranted because Zach began verbally threatening staff, aggressively kicking and punching the door (which constitutes a serious risk of harm to himself), and making physical contact with YC Gilibert's chest. Zach admitted to Detective Healey and the SIU investigator that he was "banging on his door" and he "touched" YC Gilibert's chest. The youth residents also stated that Zach was "pushing the door and was trying to get out" (youth resident 1), SYSC staff "tried to put him back in his room and close the door" but that Zach continued to "make a lot of noise" (youth resident 2), and that SYSC staff told Zach again to shut the door and he said "no" (youth resident 3). Based on these escalating behaviors by Zach, the restraint was appropriate under RSA 126-U:5, I as staff believed that Zach's behavior posed a substantial and imminent risk of serious bodily harm to himself and others. DRC's **report fails to accurately reflect the reality of Zach's behavior.** Additionally DRC's use of statements Zach made after

the incident without reference to the statements he made to investigators is misleading and biased.

Further, there is absolutely no evidence in the record, including in Zach's own statements that YC Gilibert "threw [Zach] to the ground, put his knee on Zach's back to hold him down, put his hand on [Zach's] head, and pressed his face against the ground." DRC report, page 12. In footnote 38, DRC acknowledges that there is information in the State Police Report indicating that YC Gilibert and Zach were on the floor in Zach's room during the first restraint. However, other than that one summary statement, DRC does not use any of the detailed information, including witness statements, in the State Police Report. Even Zach's own statement to Detective Healey and the SIU investigator only says that he was "thrown to the ground" and does not include any details about having a knee in his back or having his face pressed into the ground. Additionally, Zach was seen by the SYSC nurse at 3:50 pm, within 10 minutes of the incident, and there is no report of injury to his back or to his face. Supervisor White also stated that he went to Zach's door and that YC Gilibert and Zach were on the floor and that YC Gilibert then left the room. **There is no statement in Zach's interview**, any of the SYSC staff interviews, or the youth residents' interviews **supporting this version of events included in the DRC report.** And, while Zach reports that he put out his hand defensively, YC Gilibert reports that Zach grabbed Gilibert's right arm and was threatening him by saying "Fuck you I will fuck you up." By omitting details from all of the other witness statements involved, and without making any assessment of credibility, DRC's report improperly restricts the scope of information available to the public to only that which DRC wants the public to know – an objectively problematic approach.

SYSC staff had determined that a move to Room 120 was appropriate based on Zach's unsafe behavior, as that room has a camera in it. It was during this transfer process that the second restraint occurred. The restraint was appropriate under RSA 126-U:5, I as staff believed that Zach's behavior posed a substantial and imminent risk of serious bodily harm to others.

Staff, youth residents, and even Zach reported that Zach's behavior was escalating to the point where he was yelling, in response to being directed to go back into his room, "fuck that, come over here and make me get in my room" (YC Shane Arsenault); he was swearing at staff; he was pushing on the door that YC Gilibert was trying to hold closed; he was "screaming and hitting his door and swearing" and he was clenching his fists while he was standing in the doorway (youth resident 1); "he started running and swinging on staff" (youth resident 2); his door "flew open" and Zach "aggressively came out of the room, went by YC Gilibert and towards YC Arsenault" (Supervisor White). Youth at SYSC are not allowed to make "unauthorized movements" for everyone's protection. Zach was aware of this rule but chose not to follow it. Those actions, given Zach's past behavioral and criminal history of acting out physically in an unsafe manner, again, justified the MACH 1[2] restraint as he posed a substantial and imminent risk of serious bodily harm to himself and others.

[2] A MACH restraint is a Mechanical Advantage Control Hold that is part of a behavior compliance system that does not involve pain compliance or strikes but which allows staff to use body movement, leverage, joint manipulation, and mechanical advantage to effectively control a youth.

Zach was injured because all of the individuals involved in the restraint, including Zach, unintentionally fell to the floor. Supervisor White reported to Detective Healey and the SIU investigator that Zach's door "flew open," Zach "aggressively came out of the room," he went into YC Gilibert's "personal space," and was "making an aggressive move towards [YC] Arsenault." He said that it appeared that all three of the individuals, Zach, YC Gilibert, and YC Arsenault, "all fell together." YC Gilibert reported to the investigators that he and YC Arsenault were trying to restrain Zach and that YC Gilibert "landed awkwardly on Zach." The youth residents described the restraint as also resulting in a fall with youth resident 1 describing the restraint as SYSC staff tripping on Zach's legs and "it was awkward the way he fell down;" and youth resident 2 stating that Zach's forward momentum due to him running out of the room made Zach drop to the ground and that "his leaning forward [caused] all of the staff and Zach to end up falling on the ground." [3]

There are video recordings of the incident, from two different angles. **DRC has not accurately reported what the video recordings show.** Detective Healey and the SIU investigator also reviewed the video tapes of the incident and have a completely different view than the one espoused by DRC. In the video recordings, Zach is seen aggressively pushing his way out of his room and tripping on YC Arsenault's front leg resulting in all three individuals falling to the ground. DRC reports that Zach was in the prone position for "approximately 10 seconds." From review of the video, it is clear that from the instant the group fell to the floor, the staff members immediately attempted to regain their balance and control of the situation to get Zach out of the prone position and to his feet – a process that was completed in less than 10 seconds.[4]

Supervisor White confirms this in his statement to Detective Healey and the SIU investigator when he says that Zach was placed on his stomach during the restraint and Mr. White told YC Gilibert and YC Arsenault to get Zach off of his stomach and "they immediately stood Zach up." This restraint does not violate the SYSC policy or RSA 126-U as the fall was unintentional. It also does not constitute abuse under the PAIMI Act, 42 U.S.C. sec. 10802(1), as it is not a restraint on an individual with mental illness which is not in compliance with federal and state laws and regulations. Furthermore, Zach was not left in the prone position in violation of the law or policy.

DRC's report also fails to include Zach's own statements from the CSU's "Figuring Out The Problem" worksheet, which Zach hand wrote on December 31, 2016, and which he

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[3] The October 9, 2017 report from Chief Medical Examiner Jennie Duval indicates that Zach was injured when YC Gilibert landed on Zach's back during the second restraint. SYSC does not dispute that Zach was injured in the fall. However, there is no finding by Dr. Duval of abuse by SYSC staff and Dr. Duval was not provided with any of the State's investigative reports of this incident, including the witness statements, which would have assisted her in understanding how the restraint occurred.

[4] DRC also inaccurately reports that there are 2 camera angles showing the restraint. While there are 2 cameras in the CSU, one of the cameras only shows a foot in one of the frames and shows nothing else related to the restraint of Zach except the escort of Zach to Room 120.

processed with YC Gilibert as part of SYSC's Restorative Justice evidence-based practice model. On this form, Zach reports that he "was not following program room expectations so [he] was confronted [he] became unsafe so staff had to restrain [him]." Zach admitted that he was trying "to leave [his] room without permission," he "was banging on [his] door and [ ] pushed staff," "[he] was rude .. and [he] was self-destructive (hitting door). The omission of Zach's own statements, that were provided close in time to the event, and the reports of staff and other resident witnesses is extremely problematic. These actions show DRC's faulty investigative technique and its failure to attempt to explain the restraint in an objective manner.

With regard to Zach's medical care, Zach was seen by the SYSC nurse at approximately 3:50 p.m., on December 29, 2016, within 10 minutes of the incident. At that time, the nurse provided ibuprofen and ice. She rechecked him again approximately 90 minutes later. Zach saw a doctor the next morning, on Friday, December 30, 2016. The doctor prescribed ibuprofen, ice and sports restriction, which Zach himself admitted, in his statement to Detective Healey, that he played basketball after being placed on this restriction by the doctor. The doctor did not find a dislocated shoulder but suggested that Zach be x-rayed. Zach was x-rayed on the next business day, Tuesday, January 3. There were no doctor's orders finding this to be an emergency need. The scheduling of the X-ray on the next business day was consistent with the SYSC policy for non-emergencies.

6. DRC's Finding Of Abuse By SYSC Staff Is Unsupported By The Law And The Records DRC Reviewed

DRC's report finds that the conduct of the SYSC staff constitutes abuse as defined by the PAIMI Act. **This finding is unsupported by the facts and the law** and, as such, is irresponsible. Zach's behavior constituted a substantial and imminent risk of serious bodily harm to himself and others and the restraints were justified in accordance with RSA 126-U:5, I. Further, while some of the incident report forms referenced in DRC's report may include other information regarding the behavior of the other youth DRC addresses in its report, Zach's form clearly states that the restraint was necessary "to defend self or third person from imminent danger." Additionally, as detailed above, when Zach was restrained the second time, staff and Zach fell to the floor because of Zach's actions. There was no intentional or reckless act causing the "full weight of a staff person" on Zach. A fall during a restraint, without the intent to place full weight on a youth, is not a violation of RSA 126-U:4, I(b) or abuse under the PAIMI Act, 42 U.S.C. sec. 10802(1).

7. DRC's Conclusions Regarding Other Youths' Restraints Are Wrong

DRC's report, on page 17, states that there were "multiple instances in which SYSC residents were restrained even though they did not pose a substantial and imminent risk of serious bodily harm, in violation of RSA 126-U:5" SYSC denies this finding. All of the youth's files show that their behavior posed a substantial and imminent risk of serious bodily harm. SYSC specifically responds below to the other incidents included in DRC's report.

[redacted]

[redacted]

[redacted]

8. DRC Is A Mandatory Reporter

Under RSA 169-C:29, DRC is a mandatory reporter. In the draft version of its report, provided to the State on April 16, 2018, DRC identified three individuals whom it concluded were abused. However, there were no reports made to Central Intake by DRC. RSA 169-C:29 states that "[any] physician … or any other person having reason to suspect that a child has been abused or neglected shall report the same in accordance with this chapter." **DRC allegedly confirmed these situations of possible abuse yet failed to report in accordance with the law.** "An oral report shall be made immediately by telephone or otherwise…" RSA 169-C:30. In the future, DRC is expected to comply with RSA 169-C:29 and RSA 169-C:30 and provide the mandatory reports to Central Intake so that they can be promptly investigated as required by law.

9. Conclusion

SYSC is committed to providing a safe and therapeutic environment for the State's most at risk youth. We vehemently disagree with DRC's report, which appears to have been created with the sole purpose of making a finding of abuse against SYSC staff in order to further DRC's objectives. While there are always areas of improvement that can occur in any organization, the lack of objectivity and fairness in DRC's report creates obstacles to the State's goal of working with DRC collaboratively to identify and improve the services it provides to New Hampshire's youth.

Gordon J. MacDonald
Attorney General

Jeffrey A. Meyers
Commissioner

cc: Governor Christopher T. Sununu
President Chuck Morse
Speaker Gene Chandler
Moira O'Neill

ATTACHMENT A

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF HUMAN SERVICES

DIVISION FOR CHILDREN, YOUTH & FAMILIES

Jeffrey A. Meyers
Commissioner

Joseph E. Ribsam, Jr.
Director

1056 RIVER ROAD, MANCHESTER, NH 03104
603-625-5471 Fax: 603-669-1203
TDD Access: 1-800-735-2964
www.dhhs.nh.gov/djjs

2018 ANNUAL NOTICE OF RESPONSIBILITY TO REPORT INCIDENCES OF SERIOUS INJURY OR DEATH DURING A RESTRAINT OR SECLUSION

Dear Program Director:

As a facility defined in RSA 126-U:1, we are required to notify you annually of your responsibility to report incidences of serious injury or death during a restraint or seclusion. The law provides in relevant part:

126-U:10 Injury or Death During Incidents of Restraint or Seclusion. –

I. In cases involving serious injury or death to a child subject to restraint or seclusion in a facility, the facility shall, in addition to the provisions of RSA 126-U:7, notify the commissioner of the department of health and human services, the attorney general, and the state's federally-designated protection and advocacy agency for individuals with disabilities. Such notice shall include the notification required in RSA 126-U:7,

II. The department of health and human services shall annually notify facilities of their responsibilities under this section and provide contact information for the persons to be notified.

Contact information for the persons to be notified in the event of a serious injury or death during a restraint or seclusion is as follows:

Commissioner of the NH Department of Health & Human Services
c/o Division for Children Youth and Families
129 Pleasant Street
Concord, NH 03301
Telephone: (603) 271-4451 Fax: (603) 271-4729

NH Department of Justice
33 Capitol Street
Concord, NH 03301
Telephone: (603) 271-3658 Fax: (603) 271-2110

Disability Rights Center – NH
64 North Main Street, Suite 2, 3rd Floor
Concord, NH 03301-4913
Telephone: (603) 228-0432 Fax: (603) 225-2077

Thank you for your attention to this reporting requirement.

ATTACHMENT B

COPY

Jeffrey A. Meyers
Commissioner

Joseph E. Ribsam, Jr.
Director

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF HUMAN SERVICES
DIVISION FOR CHILDREN, YOUTH & FAMILIES

129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-4451 1-800-852-3345 Ext. 4451
Fax: 603-271-4729 TDD Access: 1-800-735-2964
www.dhhs.nh.gov/dcyf

December 13, 2017

Representative Kimberly Rice, Chairman
House Children and Family Law Committee
New Hampshire House of Representatives
107 North Main Street
Concord, NH 03301

Senator Jeb Bradley, Chairman
Senate Health and Human Services Committee
New Hampshire State Senate
107 North Main Street
Concord, NH 03301

Re: Annual Report Pursuant to RSA 126-U

Dear Representative Rice and Senator Bradley:

Enclosed please find a copy of the Department's report regarding the use of restraint and seclusion in facilities for the period November 1, 2016 through October 31, 2017 as required by RSA 126-U.

If you have any questions regarding this report, please feel free to contact me at (603) 271-4440.

Sincerely,

Joseph E. Ribsam, Jr.
Director
Division for Children Youth and Families

Encl.

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF HUMAN SERVICES

DIVISION FOR CHILDREN, YOUTH & FAMILIES

Jeffrey A. Meyers
Commissioner

Joseph E. Ribsam, Jr.
Director

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Thank you for your attention to this reporting requirement.

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF HUMAN SERVICES
DIVISION FOR CHILDREN, YOUTH & FAMILIES

Jeffrey A. Meyers
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If you have any questions regarding this report, please feel free to contact me at (603) 271-4440.

Sincerely,

Joseph E. Ribsam, Jr.
Director
Division for Children Youth and Families

Encl.

NEW HAMPSHIRE DEPARTMENT OF HEALTH AND HUMAN SERVICES

ANNUAL REPORT REGARDING CHILD RESTRAINT PRACTICES PURSUANT TO RSA 126-U

For the reporting period November 1, 2016 through October 31, 2017

I. SUMMARY

In 2010 the legislature passed SB 396, an act limiting the use of child restraint practices in schools and treatment facilities (Laws 2010, Chapter 375). The law was further amended in 2014 by SB396 (Laws 2014, Chapter 32). Codified at RSA 126-U, the legislation prohibits the use of dangerous restraint practices in schools and treatment facilities, establishes certain notification requirements when a restraint is used and requires the Department to report annually on the number and location of reported restraints and the status of any outstanding investigations. Attached below is a copy of the report required by the legislation.

The Department continues to work with its providers to try and limit the use of restraint and seclusion by assisting with the development of facility policy, standardizing reporting formats and reviewing compliance with the statute as part of the facilities' certification process.

II. REVIEW OF RESTRAINT RECORDS

SUNUNU YOUTH SERVICES CENTER

MONTH / YEAR	# of RSA 126-U Reportable Restraint Events	# of RSA 126-U Reportable Seclusions	# of RSA 126-U Reportable Secure Transportations	# of RSA 126-U Complaints or Investigations of Improper Use of Restraint or Seclusion	# of RSA 126-U Outstanding Investigations of Complaints for the Improper Use of Restraint or Seclusion
NOV 16	5	2	4	0	0
DEC 16	5	3	3	0	0
JAN 17	7	2	10	0	0
FEB 17	5	5	2	0	0
MAR 17	0	1	7	0	0
APR 17	9	4	1	0	0
MAY 17	9	4	0	2	0
JUN 17	3	1	5	0	0
JUL 17	12	6	4	0	0
AUG 17	9	6	2	0	0
SEP 17	4	1	1	0	0
OCT 17	8	12	2	0	0
TOTAL	76	47	41	2	0

RSA 126-U Annual Reporting, DCYF Certified Residential Treatment Programs
November 1 2016 through October 31, 2017

Outstanding Investigations of Restraint or Seclusion

Restraint	1
Seclusion	1

Intermediate/Substance Abuse and Nursing Programs

2016-2017	Totals Restraint	Totals Seclusion
Cedar Crest	0	0
Chase Home	0	0
Dover Children's Home	0	0
Orion House	2	0
Webster House	0	0

Certified Intensive, Shelter and Assessment Treatment

2016-2017 Restraint	November	December	January	February	March	April	May	June	July	August	September	October
Becket Academy- Rumney	7	2	1	4	2	0	1	0	1	19	1	0
CAST- Assessment Treatment at MPA	4	3	1	3	5	8	9	8	12	10	0	3
Crotched Mountain Rehabilitation Center	68	101	78	47	37	41	70	41	73	68	51	64
Easter Seals, Zachary Road	88	82	108	91	98	113	129	158	101	98	90	106
Easter Seals, Boys Intensive Residential Treatment Facility	0	0	0	0	0	0	0	0	0	0	1	1
Easter Seals, Krol House	0	0	0	0	0	0	0	0	0	0	0	0
Easter Seals, Lancaster	6	4	1	2	2	2	2	4	5	2	9	5
Nashua Children's Home	19	33	14	6	10	16	14	6	1	14	12	18
NFI North, Davenport School	0	0	0	0	0	0	0	0	0	0	0	0
NFI North, Midway Shelter	0	0	1	0	0	1	3	1	CLOSED	CLOSED	CLOSED	CLOSED
Pine Haven Boys Center	12	7	8	9	6	8	2	5	4	8	11	1
Spaulding Youth Center	38	26	73	60	60	52	45	56	57	49	41	49
THRIVE - Neurodevelopmental NH	not open	not open	not open	not open	not open	not open	not open	not open	not open	not open	not open	0
Traverse Interim Shelter	not open	not open	not open	not open	not open	not open	not open	not open	29	0	1	4
Wediko Children's Services, Wediko School	21	9	23	16	9	12	9	9	4	4	2	5
Vermont Permanency Initiative (Campton)	8	6	6	15	11	1	5	4	4	3	4	5
Vermont Permanency Initiative (East Haverhill Academy)	10	6	10	14	25	6	12	10	16	41	43	15
Vermont Permanency Initiative (Sub Acute)	6	3	4	6	9	5	3	2	1	4	5	3

Of the programs which use Seclusion

2016-2017 Seclusions	November	December	January	February	March	April	May	June	July	August	September	October
Crotched Mountain Rehabilitation Center "generally does not use seclusion"	0	0	0	0	0	0	0	0	0	0	0	0
Easter Seals, Zachary Road "Discontinued use of seclusion after November 2016"	6	0	0	0	0	0	0	0	0	0	0	0
Easter Seals, Boys Intensive Residential Treatment Facility "Discontinued use of seclusion after November 2016"	0	0	0	0	0	0	0	0	0	0	0	0
Easter Seals, Krol House "Discontinued use of seclusion after November 2016"	0	0	0	0	0	0	0	0	0	0	0	0
Easter Seals, Lancaster "Discontinued use of seclusion after November 2016"	3	0	0	0	0	0	0	0	0	0	0	0
Pine Haven Boys Center	18	14	12	6	12	5	6	10	8	9	10	6
Spaulding Youth Center	74	81	90	106	86	73	80	90	90	94	74	103

Month	*NEW HAMPSHIRE HOSPITAL* CHILD AND ADOLESCENT RESTRAINT/SECLUSION EVENTS					
	# Restraint Events	# Seclusion Events	# Completed Internal Investigation and Review		# Appeals or Complaints	External Review(s) Pending
			Restraint	Seclusion		
November 2016	8	53	8	53	0	0
December 2016	18	83	18	83	0	0
January 2017	24	41	24	41	0	0
February 2017	4	21	4	21	0	0
March 2017	2	23	2	23	0	0
April 2017	14	42	14	42	0	0
May 2017	21	82	21	82	0	0
June 2017	9	77	9	77	0	0
July 2017	6	83	6	83	0	0
August 2017	19	76	19	76	0	0
September 2017	10	59	10	59	0	0
October 2017	16	53	16	53	0	0

126-U reporting for foster family placements 2017

Restraint 2016-2017	December	January	February	March	April	May	June	July	August	September	October	November	
General Foster Home	0	0	0	0	1(b)	0	1(c)	0	0	0	0	1 (i)	
Specialized Foster Home	0	0	0	0	0	0	0	0	0	0	0	0	
Therapeutic Foster Homes	0	0	0	0	0	0	0	0	0	0	0	0	
Individual Service Option Foster Home	0	1(a)					1(d)	2(e, f)	1 (g)	2 (h,j)	0	1 (k)	
totals	0	1	0	0	1	0	2	2	1	2	0	2	11

level of foster care	town	investigations
a-ISO Foster Care	Bow	
b - General foster care	Nashua	reported to SIU - unfounded
c - General foster care	Manchester	reported to SIU - unfounded
d - ISO Foster Care	Bow	
e - ISO Foster Care	Bow	
f - ISO Foster Care	Bow	
g - ISO Foster Care	Bow	
h - ISO Foster Care	Bow	
i - ISO Foster Care	Weare	
j - General foster care	Manchester	reported to SIU - unfounded
k - General foster care	Manchester	reported to SIU - unfounded
l - ISO Foster Care	Bow	

a - ISO Foster Care	Hancock	

OFFICE OF THE OMBUDSMAN

The Ombudsman's Office reports that it received one complaint during the period under review that may have involved improper restraint or seclusion. Upon inquiry at the SYSC, the Ombudsman's Office learned that the administration knew of the incident and was in the process of responding.