

Disability Rights Center (DRC) is the federally authorized and funded nonprofit organization serving as the Protection and Advocacy System (P&A) and the Client Assistance Program (CAP) for individuals with disabilities in Arkansas. DRC is authorized to protect human, civil and legal rights of all Arkansans with disabilities consistent with federal law.

DRC's client is a fourteen (14) year old girl who is five feet, seven inches tall and weighs 182 pounds. Her February 7, 2006, *Assessment Report* states that she has Disruptive Behavior Disorder NOS, Depressive Disorder NOS, substance abuse and Borderline Intellectual Functioning.

Alexander Juvenile Correctional Facility (AJCF) is a juvenile correctional facility originally established as a Girls Industrial School through Act 199 in 1905 and was under the management of a state board. In the late 1970s, the Division of Youth Services began using the center to house both male and female juvenile offenders. Alexander presently serves as the primary intake and assessment center for all youth committed to the custody of the Division of Youth Services (DYS), Department of Health and Human Services.

The following report is a preliminary report of the findings and recommendations of DRC regarding two allegations of physical abuse of DRC's client. A final report will be issued when both investigations are completed.

Allegation #1:

On April 2, 2007, in response to a phone call received from the client, DRC Quality Assurance Team Leader Dee Blakley met with her at AJCF. The client told Blakley that she had been restrained facedown by staff on the floor of her dorm the week before, had trouble breathing and temporarily lost consciousness during the restraint, requiring medical attention. She told Blakley that staff had restrained her to keep her from going to another female peer's dorm room to fight. She said she had bruising to her body as a result of the restraint, but that the bruises had faded. Blakley also learned from the client she has asthma for which she was being treated at AJCF. Blakley obtained contact information from the client for her mother, to obtain authorizations for release of documents from her medical and educational files.ⁱ

The use of physical and mechanical restraint carries a risk of injury to all parties involved. In addition, there are people who have medical conditions for whom the use of prone restraint should be avoided, due to the possibility of serious injury or death from a condition called positional (or restraint) asphyxia. Positional asphyxia is defined as the insufficient intake of oxygen as a result of body position. Restraint asphyxia is defined as a form of positional asphyxiation that occurs during the restraint process. Risk factors for positional asphyxia include:

- Restraint position – prone
- Improper restraint technique = leaning into back or torso, covering face, obstructing airway
- Agitated delirium syndrome [AKA excited delirium or acute excited states] = extreme mental and motor excitement characterized by aggressive activity (with extraordinary strength and endurance) with confused and unconnected thoughts, hallucinations, paranoid delusions, incoherent or meaningless speech, and often extremely high body temperature.
- Prolonged struggle or physical exertion
- Drug and/or alcohol intoxication, esp. cocaine and methamphetamine
- Mania
- Obesity
- Pregnancy
- Exposure to pepper spray
- Respiratory syndromes, including emphysema, asthma, and bronchitis
- Pre-existing heart diseases, including enlarged heart and other cardiovascular disorders

Due to concerns about the possibility of positional asphyxia of this client during prone restraint, Blakley sent an e-mail to the AJCF Facility Administrator (FA) on April 5, 2007, informing him that she had spoken with the client's mother and expected the return of appropriate releases to review and obtain copies of the client's records. She also asked the FA to ban the use of prone restraint on this client, stating, "The juvenile informed me that she was restrained in a prone position and temporarily lost consciousness during the restraint, requiring medical attention. In addition, it is my understanding that she has asthma (for which your medical staff are treating her) and my own observations noted

that she has quite a stocky body build. The combination of these things places her at risk of positional asphyxia during prone restraints, and *I formally request an immediate ban on the use of prone restraint with this client.*" (Emphasis in original.)

The FA responded to Blakley with the date of the restraint, so DRC could request video/audio surveillance footage of the incident, which was done by e-mail to the DYS Interim Director on April 9, 2007. On April 11, 2007, Blakley went to AJCF to review and copy records. At that time, she was informed by the FA that he would not ban the use of prone restraint on the client. He cited liability of G4S in the event that Blakley reviewed subsequent incidents in which prone restraint was used, and stated that prone restraint was frequently the only way to control this client, whom he described as very physically combative. Blakley had an extensive discussion with the FA and an Assistant Facility Administrator, informing them that any form of physical restraint should be viewed not as a treatment modality, but as a treatment failure and a sign that the client's treatment plan was not effective and was in need of revision.

Blakley began an intensive review of the medical records and discovered the following:

- On March 25, 2007 four of the five staff who filed an incident report used virtually identical language to describe the restraint - "in the multiple person prone bridge." The same four staff described [client name redacted] breathing in virtually identical language also - "she tried to make herself stop breathing and medical was called." The fifth staff member at the scene used these words to describe those two situations - she was "transitioned to the sitting upper torso, then to the prone bridge," and "[client name redacted]. . .began to take short fast breaths. . . she continued to breathe rapidly. At this time, she stopped resisting and staff released her, but she then began to make choking noises, so medical staff was called."
- In addition, her medical records document a seizure on 12/20/06, during which the nurse responding to the call found [client name redacted] in her bunk "unresponsive, rigid with eyes rolled upward. Respiration shallow with occasional gurgling." She was transported by ambulance to Baptist Health ER, where she was diagnosed with "seizure - new onset seizure," and was advised to "follow-up with a specialist within one week." That did not happen. A 12/22/06 progress note states, "patient sent for history of episodes - complains of awaking with chest pain and then can't remember anything else - remembers ambulance ride hospitalization. Patient states she had a seizure at Mansfield and JDC but has never been for workup."
- Progress notes in February state on 2/11, "on 2/8 nurse called to dorm for falling and dizzy." A 2/21 progress note reports of two fainting episodes on 2/15. She was seen again at Baptist's ER on that date, with a diagnosis of syncope and collapse. On 2/21 a physician's order was finally given to get her to Arkansas Children's Hospital (ACH) for a neurological workup. On 3/7, she went, but ACH needed the reports of the EEG and EKG that had already been performed and were not brought to the clinic with [client name redacted] - nor were the

progress notes from her chart at Alexander. ACH declined to perform the same tests over again and instead recommended, "Patient to return to clinic with official reports of EEG and EKG as well as your documentation of the events."

(Emphasis in original.) One week later, there was a physician's order to get the results of the EEG and EKG and to do what ACH said.

- The marks card recorded following the incident reported facial flushing, redness on left upper arm and right forearm.
- By *Physician's Order* dated March 20, 2007, Physician states, "stop Zyprexa at patients request".

Finding that there were additional risk factors for positional asphyxia already documented in the clinical record at AJCF, Blakley sent an e-mail to the DYS Interim Director on the evening of April 11, requesting his immediate and personal attention to the case. The e-mail stated in part:

There is something medically wrong with this client and I want appropriate medical action taken now. (Emphasis in original.)

One of the reasons [Facility Administrator name redacted] has given me for refusing to ban the use of prone restraint on [client name redacted] . . . is that she gets so out of control and prone restraint is the most effective way to control her. However, on 3/20, she was allowed to discontinue taking her Zyprexa which was prescribed to stabilize her moods. It is my opinion, and her mother agrees, that she cannot be allowed to refuse her medication and be subjected to the much more restrictive "treatment" of prone restraint and the possibility of injury or death.

I request your personal attention to getting [client name redacted] to a neurologist immediately (even if DYS doesn't have a contractor readily available), banning the use of prone restraint on this client, and evaluation by [contract psychiatrist name redacted] for the administration of an appropriate mood stabilizing medication.

On April 13, 2007, Blakley received the following e-mail from the DYS Interim Director.

Thank you for bringing this issue to my attention. In response to your email yesterday, I immediately enlisted the help of several DYS personnel as well as G4S personnel (including [contract psychiatrist name redacted] and the G4S Medical Director, [physician name redacted]) to address your concerns. We have discussed this issue at length, reviewed all medical information, and will be issuing a detailed report, with directives, the first part of next week. I have been assured that appropriate precautions have been put into place.

I also confirmed that you were given the requested video footage yesterday afternoon.

The video footage reviewed by DRC painted a picture quite different from the written accounts in four of the staff incident reports.ⁱⁱ The incident occurred on Sunday, March 25, in the juvenile girls' dorm - five days after she was allowed to take herself off her mood stabilizing medication (Zyprexa). The time of day on the DVD supplied to DRC was listed as 10:12:32 a.m. The footage provided began with the client in a standing position, being held by one staff on each arm. All three were walking in circles in the area just inside the entry to the girls' dorm and the client was verbally and physically agitated, stating at various times, "I don't know what's wrong with me. . . I'm going crazy. . . I'm going to kick you." As the three individuals continued to walk in circles, the client alternately kicked the walls, doors, and glass windows of offices located close to the dorm entrance. The client made attempts to shake off the hands of the staff restraining her, jerking away from them. Male security staff responded to the incident, and female staff holding the client's arms traded off with the male security staff. The client permitted this transfer of physical restraint, but was still very verbal, saying things such as "Oh, no, no, no. . . I don't want you to touch me. . . I'm gonna hit one of ya'll. . . ya'll better get off me," and then increased her efforts to shake off the male staff, weaving in a loose "S" pattern with her body, which appeared to create problems for the male staff to continue to balance in a standing position.

The client was then "taken down" to the floor with at least four staff members holding her in a prone position. She was heard yelling, "Get off me! Get off me!" and screamed threats at staff for approximately three minutes. An unidentified staff asked her if she had taken her medication that morning, to which she responded, "I don't take that no more. Stupid ass took me off of it."

At slightly over four minutes into the prone restraint, the client stopped moving and ceased talking, still restrained by at least four staff. Staff can be heard talking and at 10:19:50 a.m., an unidentified staff said, "[client name redacted]. . . [client name redacted]!" When there was no response from the client, two staff rose and moved away from her body, with one coming around her to look at her face. At approximately 10:20 a.m., several staff voices can be heard saying, "Call a nurse! Call a nurse!" and the remaining staff discontinued the restraint and rolled the client onto her back. A radio call was made for medical assistance. At 10:21:14 a.m., a staff could be heard saying, "Has she stopped breathing?" Another staff said, "No, she's breathing."

Just before 10:22 a.m., a female staff approaching from the west corridor shouted, "Don't act like you can't breathe. . ." Then she turned to unidentified female juveniles and said, "Get your fat ass down and go to sleep. . ."

Nursing staff arrived to assess the client. As she regained consciousness, she began coughing and was still lying on the floor. At approximately 10:24 a.m., a male security staff assisted in moving the client up against the half wall that separates the entrance of the dorm from the dayroom. At 10:27 a.m., the client could be heard talking to a nurse. The video footage ended at 10:32:30 a.m., when the client was assisted down the east hall by two staff and placed in an empty cell with the door closed.

DRC was not provided with video footage of any staff attempts to verbally de-escalate the client preceding the use of physical contact to contain her. There was no documentation in the medical record in the form of therapy notes that could indicate whether a therapist was called to talk to her, or if dorm staff noted signs of increasing agitation or change of affect, and what, if anything was done to address that.

Allegation #2:

On Saturday, April 14, 2007, Dee Blakley received a phone call from the client's mother, telling Blakley that the client's father and her sisters had just returned from visiting the client at AJCF. All were quite upset at the visible bruises on the client, which allegedly occurred in her classroom when a teacher restrained her facedown on a table. The client's mother (with her sisters providing detail in the background) stated that the bruises started under her chin, down her neck and continued on her trunk and sides. The family was unable to give Blakley any further detail about the actual date of the incident or the identity of the teacher who was alleged to have restrained the client.

Blakley called AJCF and asked to speak with the FA . She was told he was not on campus. She then asked to speak with any Assistant Facility Administrator available. Blakely was told all were in training. She left a message for a return call and told the staff on the phone to pass along her request to have the client immediately taken to the campus infirmary to have photographs taken of the bruising. Blakley also stated that if there were no staff available to photograph the bruising, she wanted a return call to that effect and she would come to AJCF to take the photos.

Blakley then called the DYS Interim Director and left him a similar voice mail message. She then sent an e-mail message to him, stating, "As per the voice mail I just left you about 4 p.m. this afternoon, my request is that the infirmary take photos of the bruising reported to me by [client name redacted]'s family after they visited with her today - bruises said to start just under her chin and extend down across the chest and over to her side. . . the bruises she supposedly got last week in her classroom when her teacher pushed her facedown onto a table. I will need copies of the photos when I arrive at Alexander at 8 a.m. on Monday April 16. Naturally I will also require video footage of that event, as well as copies of documents. If the infirmary is not up to the task today - Saturday - then please notify me ASAP and I will go over with a camera and take my own photos. Then we need to talk about what is going on in her classroom and why she should not be released into the care of her family, since she seems to be continuously physically harmed at Alexander."

The DYS Interim Director returned Blakley's call at approximately 5:00 p.m. that day, and said he would contact the Facility Director and ask him to call Blakley. After one hour, Blakley contacted the Facility Director by phone, and he informed her that the infirmary had taken photos. Blakley told him she would arrive at 8:00a.m.on Monday, April 16, to begin an investigation into the new allegation.

When she arrived on April 16, Blakley met with the Assistant Facility Administrator to begin the investigation. A cursory examination of documents provided to her revealed that after refusing to turn over a plastic comb, the client and a staff member restraining her in an “upper torso” restraint fell on a nearby table, causing it to collapse and break into pieces, taking the staff and the client facedown onto the floor on top of the rubble.

The date of the incident was April 10, 2007 – one day prior to the intense and lengthy discussion Blakley had with the FA about banning the use of prone restraint with the client. Despite weeks of continuous assertions by the FA and G4S Chief Operating Officer (COO) that their corporation is “transparent,” and “we have nothing to hide,” the FA failed to disclose this incident to Blakley. AJCF’s internal investigation of the incident began simultaneously with DRC’s.

The photographs taken by the infirmary are of poor quality and do not include any taken of the client’s trunk, since a male photographer took the photos. Blakley photographed fading bruises to the client’s upper torso just above the breasts (both sides), as well as to the inner thighs and right outer thigh, inside left bicep, and above the left knee, indicating that most of the client’s weight upon impact with the table was on her left side. During her interview, she complained of pain to the left jaw.

Blakley interviewed the client and four other juvenile girls who witnessed the incident in conjunction with the Assistant Facility Administrator. Their accounts differed from those in the written incident reports of staff. What the girls described was a game of “keep-away” with the plastic comb after the Classroom Teacher had asked Female Juvenile Witness #4 to give it to him. Female Juvenile Witnesses #1 and #3 stated that a Female Classroom Staff had brought the client to her feet by placing both hands around her throat (#1) or by choking her (#3). The client and Female Juvenile Witnesses #2 and #4 said the Female Classroom Staff had made the client stand by grabbing her by her shirt collar with both hands. The four Female Juvenile Witnesses and the client used similar language to describe as well as demonstrate how the client wound up facedown on the table, i.e., she was restrained from behind by a Male Classroom Staff who shoved, pushed, slammed, or threw her onto the table. The Assistant Facility Administrator made a call to the child abuse hotline after concluding interviews with the girls, reporting both the Female and Male Classroom Staff as alleged perpetrators of physical abuse of a child. Blakley requested that neither staff be permitted contact with the client until conclusion of all investigations.

None of the girls who witnessed the incident was debriefed or given an opportunity to verbally process what they saw with a therapist or any other staff of AJCF, nor was the client. Three of the girls who witnessed the incident had recently received training from the Assistant Facility Administrator about the difference between appropriate and inappropriate physical restraints. Each of the three girls stated during their interviews that they protested what was going on as the incident was in progress and the video corroborates their accounts. They also said they had been punished afterward

for protesting and were taken from class for the remainder of the day on April 10 and all of April 11, being restricted to their dorm rooms.

Blakley and the Assistant Facility Administrator interviewed the AJCF staff responsible for the decision to punish the girls. He told them in his interview that when he arrived on the scene that the girls were too close to the staff doing the restraint and he felt it endangered all involved. (Review of the video reveals only one of the girls actually walked up to the restraint – all three were shouting loudly at staff.) When asked if he had been told by the girls why they were shouting for the staff to stop, he said all they told him was that the client should not have been restrained.

The surveillance video provided to DRC gets right to the action at 12:55 p.m. Female Juvenile Witness #4 and the client were seated across from each other at a desk and Female Juvenile Witness #4 was combing her hair. The Classroom Teacher's voice can be heard asking the girl to give him the comb and he walked toward both girls. The girls began tossing the comb back and forth to each other to avoid giving it up, in an age old game of "keep-away." Female Classroom Staff rose to try to get the comb, which on the last toss, landed on the desk in front of the client. As the Female Classroom Staff reached for the comb, she shouted that the client tried to bite her and pulled the client to her feet with her hands in the area of the client's throat. The client yelled back that she did not try to bite the staff, and then swiped at the staff's hands to make her release her.

With lightning speed, the Male Classroom Staff, who was standing in front and to the right of the client, moved around the Female Classroom Staff, hooked the client's arms from behind with his own and picked her up off the ground. After review of the surveillance video, DRC concurs with the use of the word "slammed" to describe the prone restraint maneuver executed by the Male Classroom Staff – there is just not another accurate way to describe it. (DRC does not concur that the Female Classroom Staff closed her hands around the client's throat or that she choked the client because the video is just not clear enough to draw that conclusion. A Marks sheet completed immediately after the incident does note a reddened area in the throat area, however.) The table onto which both landed came unbolted from the floor and crashed to the ground below, breaking into several pieces. For almost two minutes, the client laid in the rubble beneath the staff member before anyone tried to remove broken pieces of table from around them. At 12:58 p.m., the Classroom Teacher remarked to the client, "All you had to do was give me the comb."

Several girls in the classroom objected very loudly to what they were seeing, shouting, "Get off her. . .get the fuck off her!" and one girl approached quite close and had to be shoed away from the restraint. When additional staff arrived, one of the girls appealed to them, saying, "Get them off of her."

Staff continued to restrain the client on the floor and talk about her as if she was not there. She in turn, shouted insults and repeated over and over, "That shit hurts, get the fuck off me. . . shit, oh! Let go of me, man. . .let go of me! I didn't do anything."

By 1:05 p.m., the client was quiet and staff continued to discuss the incident. The client, who was out of camera range, but still on the floor, must have tried to move to get up, because at 1:05:30 p.m., the following exchange was heard:

Just lay there, ok?

I don't want to lay down.

Well, you got to. . .

No, I don't.

We can't let you up. . .you gotta be stripped, you gotta be searched.

Then, an arm was seen tossing the client's coat aside and a staff member retrieved it from the floor. The client was still out of camera range and DRC does not know if more of her clothing was removed.

By 1:08 p.m., the client was quiet and the staff was laughing inside the classroom. At 1:09:30 p.m., the Female Classroom Staff came back into camera range and began to verbally escalate the client again, arguing with her about whether or not she had tried to bite the staff. The client quickly calmed when the Female Classroom Staff left the room and the client was accompanied out of the classroom herself at 1:13 p.m.

On April 17, 2007, Dee Blakley and Senior Staff Attorney Dana McClain went to AJCF to meet with the client after her interview with investigators from the Arkansas State Police. During that meeting, the client told Blakley and McClain that she wished she had never reported what had happened to her to DRC. McClain asked her why she felt that way. The client said if staff got in trouble and lost their jobs, it would be all her fault. If they lost their jobs, then they wouldn't be able to take care of their children, and their kids would "turn out just like us." McClain asked her what that meant – "just like us." The client told McClain they would be kids who would be in institutions like the kids at AJCF. She also stated that she has been "beaten up" in just about every institutional placement.

Blakley and McClain explained to the client that all people, not just the kids at AJCF, are personally accountable for their own actions and must accept consequences of those actions. They told her that if staff got in trouble and lost their jobs, it would be as a consequence of their own behavior, not because the client had caused it.

On their way out of the facility, McClain and Blakley encountered the G4S Medical Director and the COO, who informed them that the use of prone restraint would not be banned for the client, she would not be required to take medication for her mood disorder, and there would be no additional neurological evaluation of her because that

had already been done and it had been determined that she did not have epilepsy. Blakley asked for a copy of the report in question.

As the Hertz commercial says, “Not exactly.” The diagnostic impression noted on the EEG report states, “Impression: Syncope. I doubt if she has epilepsy based on the limited history available. EEG today was normal during wakefulness and sleep.”

On April 18, 2007, Blakley, McClain and DRC Staff Attorney Ronetha Taylor met with the DYS Interim Director and asked him to view video footage of both incidents with them. After viewing the videos and discussing concerns related to the incidents as well as the comments of the G4S COO, the DYS Interim Director said he would meet with G4S staff that morning and would give Ms. McClain an update of the outcome of the meeting. Later that day, he informed Ms. McClain that the employment of Male and Female Classroom Staff involved in the April 10 incident had been terminated. He also said that there would be additional review of the medical record. As of the completion of this preliminary report, the client will still be subjected to the use of prone restraint.

FINDINGS AND RECOMMENDATIONS:

Findings:

DRC finds that the client has been subjected to the use of prone restraint in at least two incidents known to DRC in a relatively short period of time following her decision to discontinue mood stabilizing medication and that during each prone restraint, she has been physically injured.

DRC finds during the incident of April 10, 2007, the client was physically abused by Male and Female Classroom Staff.

DRC finds that Female Classroom Staff verbally instigated the client after she was calm during the April 10, 2007 incident.

DRC finds that juveniles are subjected to consequences for the use of profanity toward staff and each other, but there are rarely consequences for staff directing profanity toward clients.

DRC finds that the client was verbally abused while unconscious during the March 25, 2007 incident by an unidentified female staff approaching from the west corridor.

DRC finds that staff documentation of the March 25 and April 10, 2007 incidents was inaccurate, particularly when compared to the video surveillance footage of the incidents.

DRC finds that AJCF failed to conduct internal investigations of either incident until DRC brought them to the attention of G4S administrators.

DRC finds that despite the characterization of the client as physically combative and exhibiting major behavior problems, no attempt has been made to program for such behavior in the classroom in her Individualized Education Program (IEP).

DRC finds that AJCF failed to provide any meaningful manner for the client or juvenile witnesses to process their feelings about what they witnessed during the incident of April 10, 2007.

DRC finds that AJCF is not a therapeutic, clinical or rehabilitative program for the client, and she remains at jeopardy for additional injury unless she is removed from the facility.

DRC finds that you committed to DYS and placed AJCF are subjected to unreasonable risks of harm, not treated consistent with reasonable professional standards of care, and deprived of meaningful education.

DRC finds that due to an inoperable surveillance camera located in the west corridor in the girls' dormitory DRC was unable to receive complete video footage of the March 25, 2007 incident.

Recommendations:

DRC recommends that comprehensive aftercare planning begin immediately for the client and that she be discharged from AJCF to the care of her family as soon as is humanly possible.

DRC recommends that G4S immediately implement a policy regarding consequences of the use of profanity by staff toward juveniles and that consequences be sufficiently dire that they serve as an effective deterrent.

DRC recommends that all staff having contact with juveniles be certified in cardio-pulmonary resuscitation (CPR) and know the easily accessible location of one-way resuscitators for their use if needed.

DRC recommends that the contract psychiatrist train all direct care staff on the recognition of change in behavior of clients who either discontinue psychotropic medication or whose medications are changed and are receiving decreased dosages of previous medication while receiving increased dosages of new medication.

DRC recommends that all staff be trained in the risk factors for and consequences of positional asphyxia during prone restraint.

DRC recommends the immediate development and implementation of a policy for debriefing juveniles who are involved in or witnesses to any incident which causes physical and/or psychological harm to a juvenile.

DRC recommends that DYS immediately develop a procedure to sufficiently ensure the health and safety of the juveniles.

DRC recommends juveniles in the custody of DYS and placed at AJCF be treated in a manner appropriate to their needs in the most integrated setting possible as guaranteed by the Americans with Disabilities Act and Section 504 of the Rehabilitation Act

DRC recommends immediate purchase and installation of new and updated surveillance equipment in all juvenile residents' areas on campus.

ⁱ The client had also informed DRC that she has specific learning disabilities and has received special education services prior to commitment to DYS custody. Her mother informed DRC that her daughter can only read at an elementary school level, and the February *Assessment Report* states, "It is not likely that [her] other abilities will improve much until she can at least read at a middle school level."

ⁱⁱ DRC has requested the third camera angle from DYS, which was not provided with the DVD supplied.