SECLUSIONS AND RESTRAINTS

Selected Cases of Death and Abuse at Public and Private Schools and Treatment Centers

Statement of Gregory D. Kutz, Managing Director
Forensic Audits and Special Investigations
SECLUSIONS AND RESTRAINTS

Selected Cases of Death and Abuse at Public and Private Schools and Treatment Centers

Why GAO Did This Study

GAO recently testified before the Committee regarding allegations of death and abuse at residential programs for troubled teens. Recent reports indicate that vulnerable children are being abused in other settings. For example, one report on the use of restraints and seclusions in schools documented cases where students were pinned to the floor for hours at a time, handcuffed, locked in closets, and subjected to other acts of violence. In some of these cases, this type of abuse resulted in death.

Given these reports, the Committee asked GAO to (1) provide an overview of seclusions and restraint laws applicable to children in public and private schools, (2) verify whether allegations of student death and abuse from the use of these methods are widespread, and (3) examine the facts and circumstances surrounding cases where a student died or suffered abuse as a result of being secluded or restrained.

GAO reviewed federal and state laws and abuse allegations from advocacy groups, parents, and the media from the past two decades. GAO did not evaluate whether using restraints and seclusions can be beneficial. GAO examined documents related to closed cases, including police and autopsy reports and school policies. GAO also interviewed parents, attorneys, and school officials and conducted searches to determine the current employment status of staff involved in the cases.

What GAO Found

GAO found no federal laws restricting the use of seclusion and restraints in public and private schools and widely divergent laws at the state level. Although GAO could not determine whether allegations were widespread, GAO did find hundreds of cases of alleged abuse and death related to the use of these methods on school children during the past two decades. Examples of these cases include a 7 year old purportedly dying after being held face down for hours by school staff, 5 year olds allegedly being tied to chairs with bungee cords and duct tape by their teacher and suffering broken arms and bloody noses, and a 13 year old reportedly hanging himself in a seclusion room after prolonged confinement. Although GAO continues to receive new allegations from parents and advocacy groups, GAO could not find a single Web site, federal agency, or other entity that collects information on the use of these methods or the extent of their alleged abuse.

GAO also examined the details of 10 restraint and seclusion cases in which there was a criminal conviction, a finding of civil or administrative liability, or a large financial settlement. The cases share the following common themes: they involved children with disabilities who were restrained and secluded, often in cases where they were not physically aggressive and their parents did not give consent; restraints that block air to the lungs can be deadly; teachers and staff in the cases were often not trained on the use of seclusions and restraints; and teachers and staff from at least 5 of the 10 cases continue to be employed as educators. The table contains information on four of these cases.

Examples of Case Studies GAO Examined

<table>
<thead>
<tr>
<th>Victim information</th>
<th>School</th>
<th>Case details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male, 14, diagnosed with post traumatic stress</td>
<td>Texas public school</td>
<td>230 lb. teacher placed 129 lb. child facedown on floor and lay on top of him because he did not stay seated in class, causing his death. Death ruled a homicide but grand jury did not indict teacher. Teacher currently teaches in Virginia.</td>
</tr>
<tr>
<td>Female, 4, born with cerebral palsy and diagnosed as autistic</td>
<td>West Virginia public school</td>
<td>Child suffered bruising and post traumatic stress disorder after teachers restrained her in a wooden chair with leather straps—described as resembling a miniature electric chair—for being &quot;uncooperative.&quot; School board found liable for negligent training and supervision; teachers were found not liable, and one still works at the school.</td>
</tr>
<tr>
<td>Five victims, gender not disclosed, aged 6 and 7</td>
<td>Florida public school</td>
<td>Volunteer teacher's aide, on probation for burglary and cocaine possession, gagged and duct-taped children for misbehaving. No records that school did background check or trained aide. Aide pled guilty to false imprisonment and battery.</td>
</tr>
<tr>
<td>Male, 9, diagnosed with a learning disability</td>
<td>New York public school</td>
<td>Parents allowed school to use time out room only as a &quot;last resort,&quot; but school put child in room repeatedly for hours at a time for offenses such as whistling, slouching, and hand waving. Mother reported that the room smelled of urine and child's hands became blistered while trying to escape. Jury awarded family $1,000 for each time child was put in the room.</td>
</tr>
</tbody>
</table>

Source: Records including police reports, court documents, and interviews.
Mr. Chairman and Members of the Committee:

Thank you for the opportunity to discuss the use of restraints and seclusions on children and teens in public and private schools and selected treatment centers. In the context of this testimony, a restraint is defined as any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of an individual to move his or her arms, legs, body, or head freely. Seclusion is the involuntary confinement of an individual alone in a room or area from which the individual is physically prevented from leaving.¹

In certain circumstances, teachers and other staff may decide that it is necessary to restrain or seclude children in order to protect them from harming themselves or others. For example, some doctors and teachers contend that using seclusions and restraints can reduce injury and agitation and that it would be very difficult for organizations to run programs for children and adults with special needs without being able to use these methods. However, GAO has previously testified that these techniques can be dangerous because they may involve physical struggling, pressure on the chest, or other interruptions in breathing.² We found that children are subjected to restraint or seclusion at higher rates than adults and are at greater risk of injury. Even if no physical injury is sustained, we also testified that individuals can be severely traumatized during restraint. In addition, as part of our prior investigations of residential programs for troubled youth, we highlighted cases where staff at some programs employed unsafe restraint techniques, resulting in the death and abuse of teens in their care.³ Recent reports by advocacy groups indicate that similar restraint techniques have been used at public and private school throughout the country. For example, in January 2009, the National Disability Rights Network issued a report documenting dozens of

¹ These are excerpts from the definitions used by the Centers for Medicare and Medicaid Services (CMS) and they apply to all hospitals participating in the Medicare and Medicaid programs. 42 C.F.R. § 482.19(e)(1)(i)-(ii). We chose to use the CMS definitions because there are no federal statutes that apply to seclusion or restraint in the context of public or private schools.


instances where students with disabilities were abusively pinned to the floor for hours at a time, handcuffed, locked in closets, and subjected to other traumatizing acts of violence. Just a few weeks ago, the Council of Parent Attorneys and Advocates, an organization that works to protect the civil rights of children with disabilities, issued a report describing similar examples of injury and abuse. In some of the cases described in these reports, the restraints and seclusions resulted in death.

Given these prior reports and testimony, you asked us to (1) provide an overview of federal and state laws related to the use of restraints and seclusions in public and private schools; (2) verify whether allegations of student death and abuse from the use of these techniques are widespread; and (3) examine the facts and circumstances surrounding selected criminal, civil, or administrative cases where a student died or suffered abuse as a result of being secluded or restrained.

To conduct our work, we first searched for all federal and state laws pertaining to the use of seclusions and restraints in public and private schools. To verify whether allegations of student death, injury, and abuse from the use of these techniques are widespread, we gathered available data on allegations made over the last two decades by interviewing relevant experts and officials from state agencies; performing extensive Internet and LexisNexis searches; reviewing federal and state court documents related to civil and criminal litigation; and seeking leads from state investigators, agency officials, attorneys, and parent advocacy groups. Except for the case studies discussed below, we did not attempt to verify the facts related to the allegations we reviewed, nor did we attempt to evaluate cases where the use of restraints and seclusions may have been necessary or beneficial.

To select our case studies, we searched for restraint and seclusion cases from the last two decades in which there was a criminal conviction, finding of civil or administrative liability, or a large financial settlement. As part of the selection process, we focused on cases involving children from public and private schools or treatment programs in which residents attended classes; we excluded cases involving children in psychiatric facilities or juvenile detention centers. Ultimately, we selected 10 cases from 9 different states for further review. To the extent possible, we conducted interviews with related parties, including current and former school staff and officials, attorneys and law enforcement officials, and the parents of the victims. We also attempted to obtain training policies on restraints and seclusions followed at each school and treatment center involved in the cases. Further, where applicable, we reviewed police
reports; witness statements; autopsy reports; state agency oversight
reviews and investigations; and court documents, including trial
transcripts, depositions, and plaintiffs' complaints and defendants'
answers. We also conducted searches to determine whether the
individuals who restrained or secluded the children in our case studies had
previous criminal histories and whether they are still teaching or working
with children. Finally, in addition to the 10 new cases we selected for this
testimony, we also included 3 cases involving the use of face down
restraints from our previous work on residential treatment programs for
troubled youth. We performed our work from February 2009 to April 2009
in accordance with standards prescribed by the Council of Inspectors
General for Integrity and Efficiency (CIGIE).

Overview of Federal and State Laws
Related to the Use of Restraints and Seclusions

Overall, we found no federal regulations related to seclusions and
restraints in public and private schools and widely divergent laws at the
state level. We also identified at least five states that currently collect and
report information related to the use of seclusions and restraints in public
and private schools.

At the federal level, the Children's Health Act of 2000 amended Title V of
the Public Health Service Act to regulate the use of restraints and
seclusions on residents of certain hospitals and health care facilities that
receive any type of federal funds as well as on children in certain
residential, non-medical, community-based facilities that receive funds
under the Public Health Service Act. CMS has issued additional regulations
regarding the use of restraints and seclusions on patients of hospitals that
participate in the Medicare and Medicaid programs. However, there are no
federal laws restricting the use of restraints and seclusion in public or
private schools. With regard to children with disabilities, the Individuals
with Disabilities Education Act (IDEA) requires that eligible students be
educated in the least restrictive environment. IDEA also mandates that
special education students have an Individualized Education Program
(IEP), a written document that in part explains the educational goals of
the student and the types of services to be provided. IEPs are developed
by parents and school personnel and may contain instructions related to
the use of strategies to support the student. These could include, for
example, instruction approaches and behavioral interventions such as the
use of seclusion and restraints.
Furthermore, state laws and regulations in this area vary widely. For example, nineteen states have no laws or regulations related to the use of seclusions or restraints in schools. Other states have regulations, but they may only apply to selected schools in certain situations. For example, seven states place some restrictions of the use of restraints, but do not regulate seclusions. Seventeen states require that selected staff receive training before being permitted to restrain children. Thirteen states require schools to obtain consent prior to using foreseeable or non-emergency physical restraints, while nineteen require parents to be notified after restraints have been used. Two states require annual reporting on the use of restraints. Eight states specifically prohibit the use of prone restraints or restraints that impede a child’s ability to breathe. For an overview of applicable seclusion and restraint laws and regulations in all fifty states and the District of Columbia, see appendix 1. In addition to these legal requirements, we found at least four states that are currently collecting and reporting information from school districts on the use of restraints and seclusions, including Kansas, Pennsylvania, Texas, and Rhode Island.

4 Arizona, Florida, Georgia, Idaho, Indiana, Kansas, Kentucky, Louisiana, Mississippi, Missouri, Nebraska, New Jersey, North Dakota, Oklahoma, South Carolina, South Dakota, Vermont, Wisconsin, and Wyoming.

5 Alaska, Colorado, Hawaii, Michigan, Ohio, Utah, and Virginia.


9 California and Connecticut.

Although we could not determine whether allegations of death and abuse were widespread, we did discover hundreds of such allegations at public and private schools across the nation between the years 1990 and 2009.\textsuperscript{11} Almost all of the allegations we identified involved children with disabilities.\textsuperscript{12} While this number represents a small share of all children in public and private schools nationwide over these years, these allegations raise serious issues for a significant number of children, families, and those entrusted with their education and care. Although we continue to receive new allegations from parents and advocacy groups, we could not locate a single Web site, federal agency, or other entity that collects comprehensive information on this issue. For example, the Department of Education’s Office of Civil Rights receives complaints about the inappropriate use of restraint and seclusion on children with disabilities, but officials said their case management system does not have the ability to single such complaints out for tabulation. In addition, the Department of Health and Human Services funds the collection of information about investigations conducted by state child protective services agencies through the National Child Abuse and Neglect Data System, but it does not have a code to indicate whether perpetrators are teachers or staff at public and private schools.

It is important to emphasize that allegations should not be confused with proof of actual abuse. However, in terms of meeting our objective, the hundreds of allegations we found came from a number of sources, including our own research, advocacy groups, news accounts, parents, and attorneys. We often identified multiple allegations from each of our sources; for example, an attorney based in South Carolina said his office has worked on at least 15 school cases involving the restraint and seclusion of children during the last 3 years, including a student’s being shut in a classroom closet. Other examples of death and abuse claims are as follows; we do not know the outcomes of these cases.

- A 13-year-old boy with attention deficit hyperactivity disorder at an alternative public school hung himself in a seclusion room weeks after threatening to commit suicide, using a cord a teacher reportedly provided him to hold up his pants.

\textsuperscript{11}There is likely a small percentage of overlapping allegations given our inability to reconcile information from the sources we used.

\textsuperscript{12}For the purposes of this report, our definition of students with disabilities does not indicate eligibility under IDEA.
• A 7-year-old girl died at a private day treatment center after being held for hours in a face-down, or prone, restraint on the floor by multiple staff members. The staff was allegedly unaware she had stopped breathing until they rolled her limp body over and discovered she had begun to turn blue.

• A 9-year-old boy in foster care died at a public charter school after his teacher took him to a “time out” room and restrained him using a “basket hold,” which in this case was described as an adult standing behind a child, holding the child’s crossed arms and taking him to the floor. Purportedly, the boy began to make a noise like he was vomiting, then slumped over after being released. The teacher testified that she initially thought he was playing dead and joked with other staffers about planning his funeral.

• A 17-year-old boy reportedly died from an asthma attack while being restrained by a counselor at a private school for emotionally disturbed teens.

• Disabled children as young as 6 years old were allegedly placed in strangleholds, restrained for extended periods of time, confined to dark rooms, prevented from using the restroom causing them to urinate on themselves, and tethered to ropes in one public school district.

• A special education teacher at a public school was accused of using bungee cords and duct tape to fasten children as young as 5 years old to chairs designed to support kids with muscular difficulties. According to parents, their children sustained injuries such as broken arms and bloody noses while in this teacher’s class. A teacher’s aide told investigators that the woman used the restraints on a daily basis to punish the children.

• According to the father of an 8-year-old autistic boy, his son suffered from scratches, bruises and a broken nose after being put in a prone restraint by his public school teacher and aide.

• A sixth-grade special education student reportedly had his leg broken by the public school teacher who was trying to restrain him.

• A 12-year-old girl allegedly had her arm fractured by a special education teacher who put her in a “therapeutic hold,” described as being similar to a “bear hug” or hold a student’s arms behind their back.
• An autistic student at a public school claims he was strapped with his pants pulled down onto a toilet training chair for hours at a time over several days.

In addition, we were able to obtain data showing that thousands of public and private school students were restrained or secluded during the last academic year. These data do not show the inappropriate use of restraints and seclusions, but rather the number of times the techniques were used during an academic year. Specifically, Texas and California, two states that together contain more than 20 percent of the nation’s children, collect self-reported information from school officials on the use of these methods. Texas public school officials stated they restrained 4,202 students 18,741 times during the September 2007 through June 2008 academic year. During the same time period, California officials reported 14,354 instances of students’ being subjected to restraint, seclusion or other undefined “emergency interventions” in public and private schools. Other states that currently collect and report this type of information include Kansas, Pennsylvania, and Rhode Island, but we did not obtain data from these states.

### Cases of Death and Abuse Related to the Use of Restraints and Seclusions

Children, especially those with disabilities, are reportedly being restrained and secluded in public and private schools and other facilities, sometimes resulting in injury and death. The 10 closed cases we examined illustrate the following themes: (1) children with disabilities were sometimes restrained and secluded even when they did not appear to be physically aggressive and their parents did not give consent; (2) facedown or other restraints that block air to the lungs can be deadly; (3) teachers and staff in these cases were often not trained in the use of restraints and techniques; and (4) teachers and staff from these cases continue to be employed as educators. In addition to the 10 cases we identified for this testimony, 3 cases from our previous testimonies on residential treatment programs for troubled youth also show that face-down restraints, or those that impede respiration, can be deadly.

### Case Studies from Current Investigation

For our current investigation, we identified 10 seclusion and restraint cases occurring at public and private schools and selected treatment centers over the past two decades. Common themes related to the cases studies are as follows:

**Children with Disabilities:** Although we did not specifically limit the scope of our investigation to incidents involving disabled children, most of
the hundreds of allegations we identified related to children with disabilities. In addition, 9 of our 10 closed cases involve children with disabilities or a history of troubled behavior. The children in these cases were diagnosed with autism or other conditions, including post traumatic stress disorder and attention deficit hyperactivity disorder. Although we did not evaluate whether the seclusion and restraint used by the staff in our cases was proper under applicable state laws, we did observe that the children in the cases were restrained or secluded as disciplinary measures, even when their behavior did not appear to be physically aggressive. For example, teachers restrained a 4 year old with cerebral palsy in a device that resembled a miniature electric chair because she was reportedly being “uncooperative.” In other cases, we found that teachers and other staff did not have parental consent prior to using restraints and seclusions. For example, an IEP for a 9 year old with learning disabilities specified that placement in a timeout room could be used to correct inappropriate behavior, but only as a last resort. However, teachers confined this child to a small, dirty room 75 times over the course of 6 months for offenses such as whistling, slouching, and hand waving. Parents in another case gave a teacher explicit instructions to stop restraining their 7-year-old child and excluding her for prolonged periods of time. Despite these instructions, the restraints and seclusions continued. In another case, a residential day school implemented a behavior plan, without parental consent, that included confining an 11-year-old autistic child to his room for extended periods of time, restricting his food, and using physical restraints. The child was diagnosed with post traumatic stress disorder as a result of this treatment. Currently, thirteen states require schools to obtain consent prior to using foreseeable or non-emergency physical restraints.\footnote{Colorado, Delaware, Maryland, Massachusetts, Montana, New Hampshire, New York, North Carolina, Oregon, Pennsylvania, Tennessee, Virginia, and Washington.}

**Death from Face Down Restraints or Restraints that Block the Airway:** Of the hundreds of allegations we identified, at least 20 involved restraints that resulted in death. Of the 10 closed cases we examined, 4 involved children who died as a result of being restrained. In all 4 cases, staff members used restraint techniques that restricted the flow of air to the child’s lungs. In one of these cases, an aide sat on top of a child to prevent him from being disruptive and ultimately smothered him. The other cases related to the use of different types of prone restraints, a technique that typically involves one or more staff members holding a child face down on the floor. Although some of the teachers and staff
involved in these cases were trained on the use of prone restraints, the children in their care still died as a result of its use. However, we did not attempt to evaluate the types of training they received or whether they actually implemented the procedure according to the training. Currently, eight states specifically prohibit the use of prone restraints or restraints that impede a child's ability to breathe.\(^\text{14}\)

**Untrained Staff:** Although we did not evaluate specific training methods, evidence we gathered suggests that the teachers and other staff involved in our 10 closed cases were often not trained in the use of restraints. For example, staff involved in the death of a child in one case acknowledged that they were inadequately trained. A principal in another case testified that she did not know whether a substitute teacher who taped children to their chairs to make them sit still had ever been provided with the school policy on restraint. A local school board in a fourth case was found civilly liable for negligently supervising and training teachers after a 4-year-old girl was strapped to a chair for allegedly being uncooperative. A school district agreed to implement policy changes to improve training in a fifth case as part of a settlement agreement after a teacher repeatedly restrained a frail 7 year old. Lastly, in a sixth case, a volunteer teacher's aid with a history of armed burglary and cocaine possession was allowed to tape first graders to a blackboard and seal their mouths shut; we found no evidence that the school trained this aide or even conducted a background check on her before letting her into the classroom. Currently, seventeen states require that staff receive training before being permitted to restrain children.\(^\text{15}\)

**Continued Employment in Education:** Although we did not evaluate specific state licensing requirements, we did observe that in at least 5 of our cases, the teachers or other staff involved in the injurious restraint or seclusion of children continued to work with students or had licenses to do so. For example, a 280 pound teacher in Texas who fatally restrained a 129 pound teenage boy facedown on a mat currently works as a public high school teacher in Virginia. The Texas Department of Family Protective Services (DFPS) placed the teacher's name on a Texas registry

---


\(^{15}\) California, Colorado, Connecticut, Illinois, Iowa, Maine, Maryland, Massachusetts, Nevada, New Hampshire, New Mexico, New York, Oregon, Pennsylvania, Rhode Island, Texas, and Virginia.
that lists individuals found to have abused or neglected children. An administrative law judge later ruled that the woman used unnecessary force on the special education student, sustained the DFPS’s abuse finding, and affirmed that the teacher’s information should be released through the registry. Despite this listing, she is currently licensed in Virginia to instruct children with disabilities. In another example, the assistant principal who fatally restrained a child after holding him facedown on the floor for approximately an hour currently works as a principal at another public school in the same district. In addition, one of the teachers who strapped the 4-year-old child to a chair for allegedly being uncooperative still teaches at the school where the incident occurred, while the teacher who repeatedly restrained the frail 7-year-old left her school but immediately began teaching in another district in the same state. Finally, the substitute teacher who taped children to their chairs and was found guilty of unlawful restraint and battery in July 2008 still holds a state substitute teaching certificate, which does not expire until June 2009.

Table 1 provides a summary of the cases we examined; a more detailed narrative on each of the cases follows the table.

<table>
<thead>
<tr>
<th>Case</th>
<th>Student information</th>
<th>Location and type of institution</th>
<th>Year of incident(s)</th>
<th>Case details</th>
</tr>
</thead>
</table>
| 1    | Male, 14, had a history of disruptive behavior | Pennsylvania; private, nonprofit residential treatment center | 1998 | • Two staff members trained in the use of restraints pinned the student facedown on the floor for 20 minutes after he tried to attack a counselor.  
• Student died from a brain injury as a result of a lack of oxygen.  
• Death ruled an accident and no criminal charges were filed.  
• Facility settled with student’s mother for over $1 million with no admission of liability.  
• Pennsylvania banned prone restraints in 2008. |
| 2    | Male, 14, diagnosed with post traumatic stress and other disorders | Texas; public school | 2002 | • 230 lb. special education teacher placed 129 lb. student into a prone restraint and lay on top of him because he would not stay seated.  
• Student died as a result of compression of the trunk.  
• Death ruled a homicide, but no criminal charges filed.  
• Teacher currently teaches in Virginia and is licensed to instruct children with disabilities. |
<table>
<thead>
<tr>
<th>Case</th>
<th>Student information</th>
<th>Location and type of institution</th>
<th>Year of incident(s)</th>
<th>Case details</th>
</tr>
</thead>
</table>
| 3    | Male, from the age of 11 through 13, diagnosed as mentally retarded and autistic | New York; private residential school and state facility for children with developmental disabilities | 2004 and 2007 |  - Case involves two residential facilities  
  - Without notifying parents, child “ignored” and secluded in his room for extended periods of time at first facility and had access to regular meals restricted.  
  - Parents removed child from the school alleging neglect; case resulted in state law granting parents full access to investigative records in abuse cases.  
  - At second facility, student died by suffocation after an aide sat on top of him because he was being disruptive while riding in a van.  
  - The aide and driver of the van stopped at a game store and one of the employee’s houses while the child lay unconscious in the backseat.  
  - The aide was convicted of manslaughter and is currently in prison. |
| 4    | Male, 15, diagnosed as autistic | Michigan, public school | 2003 |  - Student suffered a seizure and lost control of his extremities and bladder and later became uncooperative.  
  - Assistant principal and other staff did not provide medical attention for the seizure and instead placed student in a prone restraint for approximately an hour, resulting in death.  
  - Death ruled an accident and no criminal charges filed.  
  - Mother settled a civil suit with the school district for $1.3 million.  
  - Assistant principal is now a principal at another school in the district. |
| 5    | Female, 4, born with cerebral palsy and diagnosed as autistic | West Virginia, public school | 1998 |  - Child was “uncooperative,” so teachers restrained her in a chair with multiple leather straps that resembled a “miniature electric chair.”  
  - Child suffered bruising, wet the bed, and had temper tantrums. Doctor later diagnosed child with post traumatic stress syndrome.  
  - Jury in civil case did not find teachers liable for any wrongdoing but found school board liable for negligent supervision and training in the use of restraints and awarded the family $460,000.  
  - West Virginia has since banned the use of restraints on pre-kindergarten children.  
  - At least one of the three teachers responsible for the restraint still teaches at the school. |
<table>
<thead>
<tr>
<th>Case</th>
<th>Student Information</th>
<th>Location and type of institution</th>
<th>Year of incident(s)</th>
<th>Case details</th>
</tr>
</thead>
</table>
| 6    | Four males under 6, all in special education class and one diagnosed with a condition similar to Down syndrome. | Tennessee public school | 2003 to 2004 | • To prevent a child with a Down syndrome-type condition from wandering, the teacher used sheets to strap the boy to a cot while he was wearing a 5lb., lead physical therapy vest.  
• The teacher also hit the children with a flyswatter, a ruler, and her hand.  
• Teacher pleaded guilty to felony child abuse, neglect, and misdemeanor assault and was placed on 3 years probation. |
| 7    | Male, 8, diagnosed with attention deficit hyperactivity disorder | Illinois public school | 2006 | • Substitute restrained child to a chair with masking tape and also taped his mouth shut because the boy would not remain seated.  
• Substitute found guilty of unlawful restraint and aggravated battery. He was sentenced to 2 years probation, community service, and a psychological evaluation.  
• Substitute still possesses an Illinois substitute teaching certificate, which expires in June 2009. |
| 8    | Five students, gender not disclosed, aged 6 and 7 | Florida public school | 2003 | • Volunteer teacher’s aide, a felon on probation for armed burglary, grand theft and cocaine possession, gagged and duct-taped children to their desks as punishment for misbehaving.  
• There is no record that the school trained aide or conducted a background check before allowing aide into the class room.  
• Aide pled guilty to false imprisonment and battery, was placed on 5 years probation, and ordered to attend anger management classes.  
• Aide was later arrested again for possession of cocaine. |
| 9    | Female, 7, diagnosed with Asperger’s syndrome, a form of autism | California public school | 2001 to 2002 | • Teacher secluded child in a walled off area because she refused to do work, sat on top of her because she was wiggling a loose tooth, and repeatedly restrained and abused her.  
• The student was awarded $280,000 in a civil settlement, although the school and teacher did not admit liability.  
• Teacher left the school but began teaching again in a different school district. |
<table>
<thead>
<tr>
<th>Case</th>
<th>Student information</th>
<th>Location and type of institution</th>
<th>Year of incident(s)</th>
<th>Case details</th>
</tr>
</thead>
</table>
| 10   | Male, 9, diagnosed with a learning disability | New York public school          | 1992 to 1993        | • School was only supposed to use timeout room as a last resort to correct inappropriate behavior but put child in the room 75 times over a 6 month period for hours at a time for offenses such as whistling, slouching, and hand waving.  
• The room was unlocked, but a staff person would hold it shut to prevent the child from leaving; the child’s hands became blistered while trying to escape.  
• Mother reported that the room was dirty and smelled of urine.  
• A jury in a civil suit awarded family $75,000; $1,000 for every time the child was placed in the room. |

Source: Records including police reports, court documents, and interviews.

**Case 1:** The student was a 14 year old male. He was living in a private, non-profit, residential treatment center for troubled children in Pennsylvania and attending a private school operated by the center when he died in 1998 as a result of being physically restrained. He had been placed in the custody of the non-profit by the New Jersey Department of Youth and Family Services in 1995.

According to a report by the District Attorney, on December 10, 1998, following a fight with a fellow student at a school on the treatment center’s campus, the 14 year old returned to his dormitory room. A 195 pound male counselor entered the room to counsel the 125 pound boy about the fight. The boy was agitated and attempted to stab the counselor at least three times with a pen. To prevent further attack, the counselor applied a prone restraint in which the boy ended up face down on the floor with the counselor’s left knee on the left side of his body and the counselor’s right leg across his back. At this point, the boy no longer had the pen in his hand. The counselor locked the boy’s arms behind his back. A female counselor heard the boy say, “I’m sorry I hit you” and “I hate you all.” While being physically restrained on the floor, the boy continued to yell, kick, and struggle. A 155 pound male counselor also entered the room and placed a vinyl mat under the boy’s head to prevent injury. The treatment center’s records reveal that the boy had previously been physically restrained 17 times. The treatment center would not release the boy’s treatment plan.

After approximately 12 minutes, the 195 pound counselor became tired and the 155 pound counselor took his place, locking the boy’s arms behind the boy’s back and positioning his body so that it lay off to the left side of
the boy. The 155 pound counselor physically restrained the boy for approximately 8 minutes during which time the boy continued to struggle and scream "Get the [expletive] off me, get off me." Another child reported hearing the boy yell, "Stop it, I can't breathe." The 195 pound counselor responded, "You'll be able to breathe if you stop struggling." After approximately 20 minutes of physical restraint, the student lost consciousness, and CPR was administered. The boy was taken to the hospital where he died a day later. The autopsy determined the cause of death as hypoxic encephalopathy due to compressional asphyxiation, a brain injury sustained as a result of lack of oxygen due to the compression of the student's chest.

Each of the counselors who applied the restraint that led to the boy's death were trained and certified in applying physical restraints. According to an instruction manual, employees at the center were trained in applying multiple restraints, two of which required the student to remain face down on the floor in a prone position. In his report, the District Attorney concluded that the treatment center's policy did not appear to have any inherent flaw in the technique and that the policy was well designed and appeared to have been followed by all the counselors involved. The coroner ruled that the death was accidental and the District Attorney did not file charges against the counselors.

In May 1999, the boy's mother sued the treatment center and two of the counselors who applied the restraint that led to the boy's death, alleging negligence. She claimed that the counselors used excessive force, and that the treatment center did not adequately train their counselors to deal with respiratory distress during a physical restraint. The defendants denied these allegations and said the restraint was employed for the protection of everyone involved in the situation. The counselors further stated that they acted with due care and safety of the boy.

In May 2006, before the case went to trial, the boy's mother, the treatment center, and the two counselors reached a settlement. According to the terms of the settlement, the boy's mother would be paid over $1 million. The treatment center and the two counselors did not admit any liability in the boy's death as part of this settlement. The two counselors who physically restrained the boy did not have criminal histories. They no longer work at the treatment center, but we were unable to determine whether they currently counsel children.

In October 1999, less than a year after the boy's death, the Pennsylvania Department of Public Welfare enacted regulations that prohibit child
residential facilities and day treatment centers from administering restraints that apply pressure or weight on a child's respiratory system. Consequently, we requested the treatment center provide its current policies and training manuals regarding restraints. In response, the treatment center sent us a letter stating it no longer uses prone restraints. In addition, it provided us a copy of its policy allowing physical restraints in residential treatment facilities and education programs and a workbook used to obtain certification in physical restraints. The center's policy states trained staff members are authorized to use physical restraint methods. According to the workbook, staff can apply physical force that reduces or restricts mobility while an individual is in an upright or seated position, lying face up, or in the transport of an individual from one location to another.

Case 2: The victim was a 14-year-old male who died in 2002 from being restrained by his middle school teacher at a public school in Texas. He was taken from his family at the age of nine after the Texas Department of Family and Protective Services (TDFPS)\(^{16}\) received reports that the boy and his siblings were being neglected and emotionally and physically abused, according to his foster care records. He described having to feed himself by taking food from trash cans and grocery stores. He was placed in his last foster home after being hit in the head with a shovel at the residential treatment center where he resided. Less than a year before he died, he told his therapist that his idea of a safe place was a cave with solid rock walls, a steel door, and lots of food. His most recent psychological assessment noted that the boy suffered from posttraumatic stress disorder, conduct disorder, oppositional defiant disorder, attention deficit hyperactivity disorder, and narcissistic personality disorder. The child also had a fear of not being allowed to eat and often horded food as a result of his prior abuse, according to TDFPS. The boy was in a special education class that focused on behavior management. We were unable to obtain the child's individual education plan.

The day the child died, he had been denied his lunch by school staff as a form of punishment, according to an investigation by TDFPS. Reports differ on what prompted this disciplinary action. The classroom teacher told police she gave him a "delayed lunch" because he had stopped working at about 11 a.m. and started asking if he could eat. She said this

\(^{16}\) At the time, this department was called the Department of Protective and Regulatory Services.
was a common occurrence. A teacher's aide also told police that he placed the child on "delayed lunch" at about 1 p.m. after the boy tried to steal candy. The child became agitated at about 2:30 p.m. and left the classroom, according to TDFPS. The aide ran after the boy and brought him back to the classroom, but he would not remain seated. The teacher warned him to sit down at least twice before forcibly placing him in his chair. She told police that she used a "basket hold" restraint on him while he remained seated, standing behind him and grabbing his wrists so his arms crossed over his torso. He continued to struggle, so the teacher told police she rolled him onto a mat face down into a "therapeutic floor hold" and lay on top of him. A student said his arms were pinned beneath him. The child was 5 feet 1 inch tall and weighed 129 pounds. The teacher was about 6 feet tall and weighed in excess of 230 pounds. An aide, meanwhile, held the boy's feet. The boy kicked and cursed. He repeatedly said that he could not breathe and that he was going to pass out. Multiple witnesses told investigators that he also said, "I give." After the boy became silent, the teacher continued to restrain him. An assistant principal who had entered the classroom while the boy was still struggling asked the teacher to release him, saying 15 minutes had passed. School district policy required administrator approval for extending restraint past this time period. The teacher and an aide put the child's limp body back in his chair, and the aide wiped drool from his mouth. The assistant principal told police that they thought he had been "playing possum." Once the assistant principal noticed that the child was unresponsive, she said she asked for the school nurse. The nurse arrived and performed CPR while someone phoned 911. The child was taken to the hospital and pronounced dead. A dozen students in the classroom had witnessed the incident.

Medical examiners performed an autopsy and determined that the boy died from mechanical compression of the trunk. His death was ruled a homicide and local police investigated the incident for possible prosecution. During the investigation, the teacher told authorities that the school district trained her on how to restrain students. School policy stated that restraint can be used if the child is an immediate danger to himself or others or if the child is trying to exit the classroom with the intent to leave school premises. One school district restraint trainer told police that the teacher had a very difficult classroom—the worst in the district. She also said she had reviewed the teacher's previous "therapeutic floor holds" and found no problems with the way the teacher executed the procedure.

A grand jury decided not to take action on the boy's death. TDFPS launched their own investigation and found "reason to believe" the teacher
physically abused the student on the day he died. TDFS placed her name on the department's "Central Registry," which lists individuals found to have abused or neglected children. The teacher appealed the listing to the State Office of Administrative Hearings. An administrative law judge found that the child's actions prior to being restrained did not put himself or anyone else in danger. The judge also determined that the boy had already been returned to the classroom uneventfully. The judge also found that the teacher employed the restraint as an inappropriate disciplinary tactic, using excessive, unnecessary force out of proportion to the minimal risk posed by the child's action. The teacher also ignored pleas and warnings that the child could not breathe and continued to hold him after he became still and quiet, the judge noted. Under these circumstances, the judge determined the teacher's action to be reckless and the child's death not an accident. The judge sustained the department's abuse finding and allowed the information to continue to be released to upon request to officials responsible for children. The teacher does not have a criminal record and currently works as a teacher at a public high school in Virginia. Her Virginia teaching license lists endorsements for the instruction of students in grades K-12 who have specific learning disabilities, emotional disturbances and mental retardation. We have referred this matter to the Virginia Department of Education for further investigation.

Case 3: The student was 11 when he was first abused at a private facility in New York before being smothered to death 2 years later by an employee at a state facility who restrained him in a van. The child was non-verbal and had been diagnosed as mentally retarded and autistic.

In January 2003, the family enrolled the child at a private, nonprofit residential school paid for by Medicaid. According to his parents, they were struggling to toilet train their son and had heard the school had been very successful with these situations. Initially, he appeared to be doing well, successfully using the toilet about 50 percent of the time. In the summer and fall of 2004, the boy became increasingly more aggressive and began sporadically taking off his clothes. Without parental notification or consent, the school implemented an adjusted behavioral support plan,\(^7\) called "planned ignore." As part of this plan, the child had restrictions placed on his access to regular meals. According to school documents, he

\(^7\)The school implements a Behavior Support Plan in response to maladaptive and defiant behaviors by residents. The plan attempts to address and manage these behaviors; to foster more positive, appropriate, and pro-social behavior; and to ensure the safety of the residents and their peers.
was required to be dressed in order to eat his meals. If he did not get dressed after one prompt from the staff, he was not allowed to eat his meal and received only yogurt, milk, juice or water for breakfast, lunch, and dinner. State investigations subsequently found that in a 1 month timeframe, the child missed almost 40 percent of his regular meals. When the child refused to get dressed, he also was secluded in his room for extended periods of time, while an employee held the door closed. The child’s isolation prevented him from participating in meals, school, and leisure activities. One staff member described the school’s protocol for the student as “putting him in a dark hole and giving him nothing.” During this time he missed approximately 2 weeks of classes. The school also suspended the family’s visitation rights.

In October 2004, the father said he found his son disoriented and lying naked in his own urine. The window in his son’s room was taped, pictures and toys had been removed and his son, noticeably thinner, was covered in bruises. Although the parents had not consented to any form of restraint being used against their son, school injury reports confirm that the staff did use physical restraint. The reports cite bruising and scrapes over the student’s entire body, documenting the bruises as “too numerous to count.” As a result, the parents removed their son from the school and took him home. The parents said their son seemed “emotionally damaged” and according to his psychiatrist, was suffering from post traumatic stress disorder.

As a result of allegations by the family, several New York state agencies and the district attorney’s office initiated investigations of the abuse and of the school’s regulatory compliance. Although the school was required to correct deficiencies of care identified in these investigations, no actions were taken against any of the staff involved in the incidents, and we were unable to determine whether the staff members are still working at the school. The parents then filed a complaint with the New York State Inspector General (IG) asking that it review the quality of the agencies’ investigations. The IG ultimately found deficiencies related to each investigation and recommended, in part, that the relevant state agencies take steps to ensure that abuse cases are investigated thoroughly. The IG report further stated that there is no justification for a child in a private, state-certified facility to be afforded less protection from abuse than a child in a state run facility. In addition, the child’s family worked to pass a state law, named in their son’s honor, requiring parents or guardians to be notified within 24 hours of an incident that affects the health and safety of their child. The law, which became effective in 2007, also grants parents and guardians full access to records relevant to investigations of patient
abuse and increases fines for state licensed facilities that do not comply with applicable rules and regulations.

Unfortunately, before this law was passed, the family suffered an even greater tragedy. In the fall of 2005, their son’s emotional problems escalated. He was experiencing rages and, after several trips and weeks spent in the hospital, the family could still not stabilize his behavior. In October 2005, the child was transferred from an upstate New York hospital and placed in a state-operated facility for children with developmental disabilities.

Sixteen months later, the child was on a field trip when he began acting up and was smothered to death by one of the school’s health aides. Police records indicate that during the van ride, the child got out of his seatbelt and began grabbing at another student. According to his parents, their son’s behavior plan included the use of a seatbelt buckle guard, a device that prevents the wearer from disengaging the buckle. However, to their knowledge the buckle guard allegedly was not being used that day.

Instead, one of the health aides got in the back seat of the van and first tried to restrain the child by pulling his arm’s across his chest while he was in a seated wrap position. When that did not calm the child, the aide sat on the child. .. Although the family had consented to the use of some restraints against their son, this improper restraint caused the child to lose consciousness and stop breathing.

After the child fell unconscious, neither of the employees in the van performed CPR or first aid. Instead they continued to drive around, stopping at a game store and one of the employee’s houses before finally going back to the school. In a statement made to police, the aide said “[he] realized that [the child] had stopped breathing when he stopped moving” but didn’t call anyone for help because he and the other aide were afraid of losing their jobs and going to jail. The child had been unconscious for over 30 minutes when CPR rescue efforts first began. The autopsy report cites the cause of death as cardiorespiratory arrest due to compressive asphyxia. The aide responsible for smothering the child was convicted of second degree manslaughter and is scheduled to be released from prison in 2012.

**Case 4:** This 15-year-old male died on the first day of school in August 2003 after being restrained by staff at a Michigan public high school. The student had been previously diagnosed with autism and had an Individual Education Plan (IEP) signed by his mother that summer which stated that his disability affected his ability to perform socially or academically at his
grade level. The plan described him as being inquisitive, artistic and motivated to please. It also stated that the boy enjoyed verbal praise and positive adult attention.

On the day of his death, an aide accompanied the student to a choir class with approximately 20 other students. In addition to the student, there was one other autistic student and three special education students. About 15 to 20 minutes into the class, the student’s eyes rolled back into his head, his body began to convulse, and he lost control of his bladder. The aide stated that she believed the student was having a seizure. She placed the student on the floor and after several minutes, another aide pressed the room’s emergency button. The school’s assistant principal responded to the classroom and decided that the student did not need medical attention. He instructed another staff member to call the student’s mother to pick him up.

Approximately 10 minutes after the seizure, the student got up but seemed unsteady so the instructional aide tried to assist him into a seated position. At this point, the student jumped up and began flailing his arms. The choir teacher, who had moved her students to another part of the room to continue the class, made another call for assistance and the assistant principal returned, this time accompanied by another aide. Shortly thereafter, the student began to scream and flail his arms again. According to the assistant principal’s written statement, he believed that the student might hurt himself or others, so he and the two aides placed the student in a full restraint facedown on the floor. Specifically, the assistant principal was holding the student’s arms behind his back, one of the aides held his legs down, and the other was holding his shoulders. The assistant principal went on to state that it was very difficult to hold onto the student and that every time they relaxed the restraint, he would begin to struggle again. They restrained him in this manner for approximately an hour, but did not call any medical professionals to attend to the student during this time.

The assistant principal and the aides eventually stopped the restraint when a man and woman who were friends of the mother arrived to pick the student up. The male friend tried to talk to the student but he did not respond. Both the assistant principal and the two friends thought the student looked strange and asked the school staff to call 911. The assistant principal checked the student and said he felt a pulse, but the female friend stated that he was not breathing. The assistant principal checked again for a pulse and found none, so the female friend started CPR. The assistant principal, who had an expired CPR certification, assisted by pinching the student’s nose closed. Police and firefighters arrived and
continued CPR for an additional 30 minutes until paramedics transported the student to a hospital, where he was pronounced dead. In the autopsy report, the medical examiner concluded that the student had suffered an apparent seizure and further wrote that “restraint in the prone position of emotionally and physically agitated individuals is recognized as being associated with sudden death, even without significant chest or neck compression.” The official cause of death was listed as “prolonged physical restraint in prone position associated with extreme mental and motor agitation.” His death was ruled an accident and no criminal charges were filed.

In 2006, the student’s mother settled a civil case against the school district and the regional educational services agency for $1.3 million. In her deposition, the choir teacher stated that she had no idea the student was autistic until she saw him walk into the class with his aide and that she had no prior information on the student. In his deposition, the school’s principal testified that neither he nor the assistant principal had received training about the dangers of restraining an individual on the floor. The aide who had held the student’s feet to the floor also testified in a deposition that he was never given any advice or information on restraining students. Further, according to an instructor who had provided training that included the use of restraints to both the Regional Educational Service Agency (RESA) and school district staff testified, the instructional aide who accompanied the student into the class had last received such training in 1987. At the time of the incident, the instructor said that training, which includes the use of restraints, was offered to school district employees but the decision about who had to be trained was left to principals or program supervisors.

As of April 2009, the assistant principal who made the decision to restrain the student currently serves as the principal of the district’s middle school and one of the other staff members who restrained the student is currently employed by the district’s regional educational service agency. We were unable to determine whether the other staff members are still employed by this or any other school district. None of the staff members who restrained the child had any criminal histories.

As a result of this student’s death, and another student death in 2003 caused by improper restraint, a member of the Michigan State Board of Education (SBE) told us that SBE changed its recommended policies on the use of restraints and seclusions. However, though the policy encourages local school districts to collect and report data on the use of these techniques to the Michigan Department of Education, the board
member expressed doubt that this was actually done. In each year since the policy was enacted, the member said that she has requested any statistics or reports on the use of seclusion and restraints but has never received any information.

**Case 5:** The child in this case was an adopted, 4-year-old female who was strapped to a chair by her teacher at a West Virginia public school. The child was born with cerebral palsy and was later diagnosed with autism. In February 1998, she started special education classes and shortly thereafter, began to have tantrums and wet her pants at school. According to the child's mother, these behaviors continued at home and, even though the child was toilet trained. Her mother also said that the girl began coming home from school with bruises covering her calves, chest, and wrists.

According to the school and teachers, after the girl was enrolled in school for just 10 days, her mother arrived at school to pick her up and was told by a teacher's aide that she was being uncooperative and had been restrained in a chair for medically fragile children. The mother later claimed that, because the child was autistic, she would act up when she needed to use the bathroom. The school and teachers stated that they put her in the chair because she was "uncooperative." According to the mother, the chair resembled an electric chair and was high backed with multiple leather straps across the arms, chest, lap, and legs. The mother told the school to never use the chair again.

That same day, the child's mother removed her daughter from the West Virginia Elementary School and reported the bruises and use of the restraint to the State Board of Education. When the Board provided no help, the mother sued the school district alleging, among other things, that the school's actions directly and proximately caused and will continue to cause her daughter great psychological and emotional stress, developmental delays, trauma, fears, and pain and suffering. The jury found that the defendants did not discriminate against the child, violate the child's constitutional rights, commit assault and battery against the child, or falsely imprison the child. However, the jury did find the school board liable for negligently supervising and training three teachers in the use of restraints, which proximately caused injury and awarded the mother and child $460,000 for mental pain and suffering and the mother's lost wages.

We contacted the school district to see if any corrective actions have been taken to prevent similar incidents from occurring. According to the
school's superintendent, the school district no longer uses restraints. Unrelated to the case, West Virginia also promulgated a state regulation stating that school personnel in a pre-kindergarten classroom may not restrain a child by any means other than a firm grasp around a child's arms or legs and only for as long as necessary.

According to the family's attorney, a doctor diagnosed the child with post traumatic stress disorder as a result of the restraint. Although she is now 15 years old, her mother says that she has still not returned to school and suffers anxiety when she sees a school or hears the word "teacher." In addition, she will not use public restrooms because she believes that it is wrong to urinate in public. At least one of three teachers responsible for restraining the child is still teaching in the same school.

Case 6: The four students, all males all under 6 years old, attended a special education class in a Tennessee public school, where they were assaulted and physically restrained by their teacher between early December 2003 and mid-March 2004. One of the children was diagnosed with a condition similar to Down syndrome, according to his parents.

The school had received complaints about the teacher after the 2002 to 2003 school year, prompting the Director of Special Education for the county to initiate an inquiry. As a result of these complaints, the school system developed a corrective action plan, which included installing a surveillance camera in the teacher's classroom, mentoring, and direct supervision by the school's Special Education Director.

Despite these corrective measures, the teacher's interactions with the children did not improve during the following school year. Specifically, to prevent the child from wandering, the teacher tied the child suffering from the Down syndrome type-condition to a cot with a sheet while he was wearing a 5 pound lead physical therapy vest, which was supposed to be used to help with the child's posture. The child's mother asked that school staff not restrain her son since it would be difficult to free him in the event of a fire. Despite her request, the teacher allegedly continued to restrain the boy, sometimes so tightly that a teacher's aide would spend 5 minutes or more trying to unravel the knots. In addition to the restraint there were claims that the teacher hit the children with a flyswatter, ruler, and her hand, according to a complaint filed with the Tennessee Department of Children's Services.

The Board of Education suspended the teacher in March 2004 and dismissed her in June 2004. In June 2005, a grand jury indicted the teacher
on 14 counts of child abuse and 14 counts of assault. The teacher, who had no prior criminal convictions, pled guilty to one count of felony child abuse and neglect and three counts of misdemeanor assault. In February 2007, according to the terms of her plea agreement, she was placed on 3 years of probation but did not serve any jail time. According to the assistant district attorney general who handled the case, it was challenging because state law requires proof that the children were harmed, such as pictures of bruises or statements from doctors and there was no such evidence. He also said that the teacher’s guilty plea and subsequent felony conviction for child abuse guaranteed that she would never be able to teach again in Tennessee. Tennessee revoked her teaching license, but we were unable to determine whether she is teaching or otherwise interacting with children in any other state.

**Case 7:** An 8-year-old boy was restrained by a substitute teacher who used masking tape to strap him to a chair and seal his mouth at an Illinois public school in March 2006. The child, who was diagnosed with attention-deficit hyperactivity disorder, attended a special education class with up to eight other students with various emotional or physical disabilities.

On the day of the incident, the substitute told the 8 year old and another male student in the class that they would not be allowed to play during their free time and told them to draw at their desks. In a written statement, the substitute told police that he disciplined the boys because they were “acting up and causing problems.” The substitute testified that the two boys still did not remain in their seats, so he told them to sit in their chairs and put their hands behind their backs, and then he wrapped masking tape around their arms. After the boys broke free, the substitute taped them again in the same manner. The substitute testified that the students were “laughing” so he placed tape over each of their mouths and returned his attention to the class. After the 8 year old began “mumbling,” the substitute removed the tape from his mouth and the child told him “his arms hurt.” In a hand-written note the substitute left for the class’s regular teacher, he wrote “I hope I didn’t do something wrong by masking taping [the boys] to their chairs for a couple minutes. They were laughing most of the time when I did it.”

The 8 year old reported the incident to his after-school daycare provider, according to the Illinois Department of Children and Family Services (DCFS). DCFS coordinated its efforts with law enforcement as well as the county’s victim advocacy center and the State’s Attorney Office and a grand jury ultimately charged the substitute with two felony counts of unlawful restraint and two felony counts of aggravated battery. During the
trial, the school’s principal testified that district policy allowed physical restraint in limited circumstances: to prevent students from harming themselves or damaging property or to remove a student who will not voluntarily leave an area. The principal also testified she did not know whether the substitute was ever given these policies.

A jury found the substitute guilty of one count of unlawful restraint and one count of aggravated battery in July 2008. The substitute was sentenced to 24 months probation, fined $1,500, perform 80 hours of community service, and undergo a psychological evaluation. The substitute still holds an Illinois state substitute teaching certificate that expires in June 2009. Prior to this incident, the substitute had been arrested in 2001 for driving under the influence of alcohol. He was sentenced to 18 months supervision and treatment for alcoholism, and fined $1,500.

Although this case was successfully prosecuted, individuals we interviewed from the State’s Attorney Office and Equip for Equality (Illinois Protection and Advocacy Service) told us that seclusion and restraint cases involving children and adults with physical or mental disabilities typically have low rates of prosecution. The State’s Attorney Office cited reasons such as the reluctance to further traumatize victims by having them testify, the stereotype that special needs children are unreliable witnesses, and sympathy for teachers and other staff seen as working with challenging individuals who might need to be secluded or restrained. In addition, Equip for Equality officials told us these incidents may also go underreported if children are not able to relate their experiences because they may be unable to communicate orally.

Case 8: The students were five first grade children restrained by a volunteer teacher’s aide at a public elementary school in Florida in August and September 2003. The volunteer aide, who had a prior criminal record, was charged with child abuse and false imprisonment for using tape to restrain and gag her students as punishment for misbehavior.

The students, aged 6 and 7, were bound with tape in a variety of ways. The aide lashed their arms to their laps, tied their ankles together, strapped their bodies to their desks, fastened their heads to the blackboard and sealed their mouths shut. A portion of one child’s hair was snatched off when the aide forcibly removed the tape. We could find no evidence to indicate that the school trained or conducted a background check on the aide, who was at the time a felon on probation for armed burglary, cocaine possession and grand theft.
After the students filed a complaint with the police, the aide surrendered and was charged with five felony counts of child abuse. She pled guilty to four counts of false imprisonment and one count of misdemeanor battery in January 2005 and was placed on 5 years probation, with the possibility of early termination of this probation after 2 and a half years and completion of all special release conditions, which included serving 75 hours of community service, taking classes in parenting and anger management, and having no contact with the students. Approximately a year later the aide was again arrested, this time for possession of cocaine and drug paraphernalia. A law enforcement officer witnessed her with a crack pipe.

**Case 9:** The student was a 7-year-old female enrolled in a special classroom at a public school in California when her teacher began secluding, restraining, and abusing her. The student, a small, frail girl weighing only 43 pounds, was diagnosed with Asperger’s Syndrome, a form of autism characterized by language impairment and poor social skills.

According to the student’s mother, the teacher secluded the girl in a walled off area in the back of the classroom accessible by only one door because she refused to do her school work. The mother alleged that when the teacher discovered that her daughter was wiggling a loose tooth, the teacher physically restrained her by making her lie face down on the floor and sitting on top of her. When the student came home from school that day, she complained to her mother, “Mommy, Mommy, my teacher hurt me, and I couldn’t breathe.” In June 2001, the student’s mother sent a letter to the teacher instructing her to discontinue all physical restraints on her daughter. Despite these instructions, the parents alleged that restraint and other physical abuse continued. They also alleged that the girl was frequently left in seclusion for 3 hours at a time for refusing to do work. In December 2001, the parents met with the principal and the teacher and ordered the teacher to stop all physical restraints and prolonged seclusions, placing these instructions in the child’s IEP.

The restraint and other mistreatment continued, according to the parents. In April 2002, the parents alleged that the teacher admitted to smearing the contents of a burrito all over the student’s face and hair after she refused to eat. In July, the parents removed their daughter from the school after the teacher allegedly physically restrained her at least three times in one day during summer school. Furthermore, according to the parents' complaint, the teacher kicked the student, spun her around, and dropped her on her head. When her mother picked her up from school that day, the
child had a severe abrasion to her arm, a one-inch diameter bruise on her right shoulder, and a bump on the right side of her head. The student told her mother she was “hurt all day” by her teacher. The teacher later said she restrained the student because she was a danger to herself and others. Furthermore, the teacher said the student had threatened her by waving a pair of scissors at her. According to the teacher, while she was restraining the child, her arm gave out and the student fell to the floor, injuring herself. The school’s principal stated that the teacher received training once a year in applying restraints. However, this was not the first time the teacher had been accused of physically mistreating a child. Prior to the July 2002 incident, the teacher was accused of using excessive force while restraining another child in her classroom. However, the teacher did not have any prior criminal convictions.

The student’s family sued the teacher, multiple school officials, and the school district. At trial, the teacher and school’s principal were found liable for negligence and civil rights violations and the school district was found liable for civil rights violations. The family was initially awarded $700,000 in damages. According to the student’s attorney, to avoid an appeal by the school district, the family settled with the school district and school officials. As part of the settlement agreement, though, the school district and school officials did not admit any liability. The student’s family was ultimately awarded $260,000. In addition, the parties agreed to a 2-year period of judicial oversight during which the school district would be required to institute policy changes related to the discipline and behavior management of special needs children in order to achieve the goals of training, supervision, and accountability.

The school officials involved with this case are no longer employed with the school district, according to the student’s attorney. However, in October 2002, the teacher began teaching in a different school district, where she remained until June 2005. She currently holds a valid California state teaching license, but we were unable to determine if she is employed as a teacher. The student is now home-schooled and living in a different state. According to the student’s mother, the girl has never fully recovered from her experience.

Case 10: The student was a 9-year-old male with a learning disability who was secluded in a time out room repeatedly while enrolled in second grade in a New York public school. As part of his educational plan, his mother agreed to an IEP to assist with his learning disability. The IEP specified that the school may put the child in a 'time-out' room to correct inappropriate behavior, but only as a last resort. However, school records
show that the student was placed in the time-out room regularly—75 times over a 6 month period during the 1992-1993 school year, occasionally for an hour or longer. The reasons for the confinement logged by the teachers included behaviors that were not physically aggressive; examples include, “whistling,” “slouching,” and “waving hands.” In order to reach the room, the child was escorted out of his classroom in front of his peers, down a hallway, and to a location by the school auditorium. Although the door to the room was unlocked, a staff person would hold the door of the room closed to prevent him from leaving, and the child’s hands became blistered at least once while trying to escape. On at least one occasion, the child claims he was physically restrained facedown on the floor. The school district felt that this approach was reasonable; however, a psychologist said that the child suffered from attention deficit hyperactivity disorder (ADHD), and his attorney argued that perhaps he couldn’t control the behaviors that led to his confinement. As shown in pictures taken by the child’s mother, the time-out room was small—approximately the length of an adult’s arm span—and was lined with ripped and dirty padding. In addition, the student’s mother reported that the room lacked ventilation and had an odor of “dirty feet and urine.” When she visited the room and observed the conditions there, she requested that her son be transferred to another school.

The student brought a civil suit against the school district, alleging false imprisonment, negligent infliction of emotional distress, and a violation of the prohibition against unlawful seizure under the Fourth Amendment of the U.S. Constitution. The court awarded $75,000 to the student’s family plus legal fees—$1,000 for each of the 75 times that the child was placed in the room. Based on our investigation, none of the educators associated with this case appear to have a criminal history. We were unable to determine whether they are still teaching.

Cases Involving Restraint from Previous Work

The following three cases from our previous work on residential treatment programs confirm the finding that face down or other restraints that block the airway can be deadly. In these cases, staff members restrained the victims by holding them face down in the ground, resulting in death by severed artery, suffocation, and abnormal heartbeat, respectively. In addition, all the teens in these cases were diagnosed with disabilities.
Table 2: Summary of Cases from Previous Work on Residential Treatment Centers for Troubled Youth

<table>
<thead>
<tr>
<th>Case</th>
<th>Victim information</th>
<th>Program attended</th>
<th>Date of death</th>
<th>Case details related to use of restraint</th>
</tr>
</thead>
</table>
| 1    | Male, 15, Oregon resident | Oregon wilderness therapy program | 2000 | Refused to return to campsite but did not behave violently.  
Restrained by staff and held face down to the ground for almost 45 minutes.  
Died of severed artery in neck. |
| 2    | Male, 12, Texas resident | Texas residential treatment center | 2005 | Victim was angry and started banging his head against the ground.  
A 5 feet, 10 inch, muscular staff member placed the 87-pound victim into a facedown restraint.  
Several witnesses claimed they saw the staff member lying across the back of the victim.  
Victim complained he couldn’t breathe and eventually became unresponsive, at which point the staff member removed the restraint.  
Attempts to revive victim failed. |
| 3    | Male, 16, Pennsylvania resident | Pennsylvania psychiatric residential treatment center | 2006 | Victim was placed under “intense observation” for attempting to run away from the program.  
Victim was ordered to put the hood of his sweatshirt down so that staff could see his face, but victim refused.  
Three staff members brought the victim to another room and placed him in facedown restraint.  
After 10 minutes of the restraint, victim complained that he couldn’t breathe.  
Victim died at the hospital 3 hours later from an abnormal heartbeat. |

Sources: Records including police reports, court documents, and interviews.

**Case 1**: The victim was a 15-year-old male who died while being restrained by two counselors. According to the victim’s mother, in 2000 she enrolled her son in a wilderness program in Oregon to build his confidence and develop self-esteem in the wake of a childhood car accident. The accident had resulted in her son sustaining a severe head injury, among other injuries. According to her lawsuit, her son left the program headquarters on a group hike with three counselors and three other students. Several days into the multiday hike, the victim refused to return to the campsite after being escorted by a counselor about 200 yards to relieve himself. Two counselors then attempted to lead him back to the campsite. According to an account of the incident, when he continued to refuse, they tried to force him to return and they all fell to the ground together. The two counselors subsequently held the victim face down in the dirt until he stopped struggling; by one account a counselor sat on the victim for almost 45 minutes. When the counselors realized the victim was
no longer breathing, they telephoned for help and requested a 911 operator's advice on administering CPR. While the mother was driving to the hospital, her son's doctor called, advised her to pull to the side of the road, and informed her that her son had died. The victim's mother told us that she was informed, after the autopsy, that the main artery in her son's neck had been torn. The cause of death was listed as a homicide.

In September 2000, after the boy's death, one of the counselors was charged with criminally negligent homicide. A grand jury subsequently declined to indict him.

In early 2001, the mother of the victim filed a $1.5 million wrongful death lawsuit against the program, its parent company, and its president. The lawsuit was settled in 2002 for an undisclosed amount.

Case 2: The victim, who died in 2005, was a 12-year-old male. Documents obtained from the Texas Department of Family and Protective Services indicate that the victim had a troubled family background. He was taken into state care along with his siblings at the age of 6. As a ward of the state, the victim spent several years in various foster placements and youth programs before being placed in a private residential treatment center in August 2005. The program advertised itself as a "unique facility" that specialized in services for boys with learning disabilities and behavioral or emotional issues. The victim's caretakers chose to place him in this program because he was emotionally disturbed. Records indicate that he was covered by Medicaid.

On the evening of his death, the victim refused to take a shower and was ordered to sit on an outside porch. According to police reports, the victim began to bang his head repeatedly against the concrete floor of the porch, leading a staff member to drag him away from the porch and place him in a "lying basket restraint" for his own protection. During this restraint, the 4 feet 9½ inch tall, 87-pound boy was forced to lie on his stomach with his arms crossed under him as the staff member, a muscular male 5 feet 10 inches tall, held him still. Some of the children who witnessed the restraint said they saw the staff member lying across the victim's back. During the restraint, the victim fought against the staff member and yelled at him to stop. The staff member told police that the victim complained that he could not breathe, but added that children "always say that they cannot breathe during a restraint." According to police reports, after about 10 minutes of forced restraint, the staff member observed that the victim had calmed down and was no longer fighting back. The staff member slowly released the restraint and asked the victim if he wanted a jacket. The
victim did not respond. The staff member told police he interpreted the victim’s silence as an unwillingness to talk because of anger about the restraint. He said he waited for a minute while the victim lay silently on the ground. When the victim did not respond to his question a second time, he tapped the victim on the shoulder and rolled him over. The staff member observed that the victim was pale and could not detect a pulse. All efforts to revive the victim failed, and he was declared dead at a nearby hospital.

Although the Texas Department of Family and Protective Services alleged that the victim’s death was because of physical abuse, the official certificate of death stated that it was an accident and a grand jury declined to press charges against the staff member performing the restraint. However, the victim’s siblings obtained a civil settlement against the program and the staff member for an undisclosed amount.

Case 3: The victim was 16 years old when he died, in February 2006, at a private psychiatric residential treatment facility in Pennsylvania for boys with behavioral or emotional problems. He was a large boy—6 feet 1 inch in height and weighing about 250 pounds—and suffered from bipolar disorder and asthma. The cost for placement in this facility was primarily paid for by Medicaid.

According to state investigative documents we obtained, the victim was placed in intensive observation after he attempted to run away. As part of the intensive observation, he was forced to sit in a chair in the hallway of the facility and was restricted from participating in some activities with other residents. On the day of his death, staff allowed the victim to participate in arts, crafts, and games with the other youth, but would not let him leave the living area to attend other recreational activities. Instead, staff told the victim that he would have to return to his chair in the hallway. In addition, staff told him that he would have to move his chair so that he could not see the television in another room. The victim complied, moving his chair out of view of the television, but put up the hood of his sweatshirt and turned his back toward the staff. The staff ordered him to take down his hood, but he refused. When one of the staff walked up to him and pulled his hood down, the victim jumped out of his chair and made a threatening posture with his fists, saying he did not want to be touched. The staff member and two coworkers then brought the victim to another room and held him facedown on the floor with his arms pulled up behind his back. The victim struggled against the restraint, yelling and trying to kick the three staff members holding him down. After about 10 minutes, the victim became limp and started breathing heavily. He
complained that he was having difficulties breathing. One staff member unzipped his sweatshirt and loosened the collar of his shirt, but rather than improve, the victim became unresponsive. The staff called emergency services and began CPR. The victim was taken by ambulance to a hospital, where he died a little more than 3 hours later. In the victim's autopsy report his death was ruled accidental, as caused by asphyxia and an abnormal heartbeat (cardiac dysrhythmia).

No criminal charges were filed in regard to the victim's death. The victim's mother filed a civil suit over her son's death against the facility. The suit was pending at the time we completed our investigation.

Mr. Chairman and Members of the Committee, this concludes my statement. I would be pleased to answer any questions that you or other members of the committee may have at this time.

Contacts

For further information about this testimony, please contact Gregory D. Kutz at (202) 512-6722 or kutzg@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this testimony. In addition to the individual named above, the following individuals made key contributions to this testimony: Cindy Brown Barnes, John W. Cooney, Jennifer L. Costello, Paul R. Desaulniers, Eric G. Eskew, Georgeann M. Higgins, Christine A. Hodakievic, Jason Kelly, Barbara C. Lewis, Otis S. Martin, Flavio Martinez, Vicki R. McClure, James Murphy, Andrew A. O'Connell, Mary V. Osorno, Anthony A. Paras, Ramon J. Rodriguez, Kira Self, and Emily C.B. Wold.