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18 September, 2014

Kristi Padgett, Administrator
Yell County Juvenile Detention Center
P.O. Box 1688
Danville, Arkansas 72833

In re: Use of The WRAP Restraint

Dear Kristi:

As the juvenile ombudsman, I have no authority regarding the operation of your detention facility. I do have authority to monitor conditions regarding youth committed to the Division of Youth Services (DYS). Your facility currently houses youth committed to DYS pursuant to a memorandum of understanding between Yell County and DYS. As such, I entered your facility on September 4, 2014 to interview youth committed to DYS housed at the Yell County Juvenile Detention Center.

On that date, there were nineteen (19) youth housed in your detention facility committed to DYS. During the course of my individual interviews, multiple youth reported concerns about the use of a restraint procedure they referred to as "getting wrapped." Each youth described the process and were consistent in their detail and descriptions. Several of the males indicated that while restrained, they were placed in view of other youth, particularly youth housed in Pod A. The evening of my interviews, Pod A housed the female population. One of the females I interviewed confirmed having witnessed other detainees restrained in the manner described. All of the youth whom I interviewed that reported having been restrained in the WRAP and the youth who witnessed other youth in this restraint were consistent in their description: "It is torture. This should not happen to kids."

I met with the DYS executive staff on September 5 to report my initial concerns. I indicated that I had not had opportunity to discuss these issues with you and that I was returning to your center on September 5 to further investigate. I was accompanied by a DYS Jail Compliance Monitor. You provided your center's policy manual and information on the use of the WRAP. Additionally, you provided a copy of an incident report for a DYS-committed youth who had been restrained in the WRAP. Upon my

request, your team applied the WRAP restraint procedure on me and afforded me opportunity to interview a DYS-committed youth while I was restrained in order to confirm that the process and mechanism were similar to his experience.

I returned to your facility on September 9 to conduct additional follow up regarding documentation of the use of restraints in your center. Pursuant to the Policies and Procedures manual you provided me, Section 6-1012 governs the use of mechanical restraints. In paragraph three of this Section regarding Procedure the use of mechanical restraints is restricted to the following circumstances:

Protection of the juvenile from self-injury
Prevention of injury to others
Precaution against escape during transportation
For medical reasons under direction of medical staff
Prevention of property damage

I would suggest consideration of the following language under Procedure in Section 6-1012 to include: ***Restraints in emergent situations shall only be used as a last resort. A restrained resident will be within arm's reach of a staff member at all times while the restraint device is being used. A staff member shall remain with the resident until the restraints are removed.***

Section 6-1013 governs the use of force in your center. Paragraph Three, subsection D provides a description regarding reports, specifically:

> The Administrator or his/her designee shall be notified immediately when any type of force is used. An incident report, prepared by the staff member who employed force, shall be completed no later than the conclusion of that shift and it shall include:
>
> - An account of the events leading to the use of force.
> - An accurate and precise description of the incident, and the reasons for employing force.
> - A description of the force or restraining device, if any, and the manner in which it was used.
> - A description of the injuries suffered, if any, and the treatment given and/or received.
> - A list of all participants and witnesses to the incident.

In the specific incident involving the use of restraints that we reviewed on September 9, I shared with you my personal view that the incident in question did not appear to rise to the level described in your policy to merit the use of mechanical restraints. We further discussed that the level of documentation afforded regarding this incident was insufficient.

Review of your policy and procedures regarding incident reporting when the use of force is applied demonstrates several specific insufficiencies. I would suggest your consideration of revising your policy in these regards to include:

> A ***detailed*** account of the events leading to the use of force ***including efforts to deescalate the situation***.
>
> A description of the force or restraining devices, if any, ***including protective head gear and/or spit/bite guard,*** and the manner in which used.
>
> ***The time the incident began, the time the restraints were placed on the resident, and the time the restraints were removed from the resident.***
>
> ***The time the Administrator or his/her designee was notified of the incident.***
>
> A list of ***all staff members on duty, resident(s) involved and*** witnesses to the incident.
>
> ***The date and time the incident report is completed.***

Following the use of force, specifically the use of any mechanical restraint, I would advise completion of a mark sheet of the juvenile(s) involved to demonstrate the occurrence of, or lack of, any injury or marks as a result of the restraint or efforts to restrain. Policy and practice should also demonstrate a written administrative review of all documentation related to the use of restraints with the reviewing administrator signing off on the review indicating that policy and procedures were followed, efforts to deescalate the situation were valid and the use of force was justified, including the length of time the use of force was employed. This administrative review should also include documentation of any administrative findings and recommended follow up for both staff, if indicated, and resident(s).

As we discussed, I have significant concerns regarding the manner in which restraints are being used in your center. In particular, the use of the WRAP appears to present risk to the juvenile of head injury. I recognize that as part of the training afforded your staff, instruction is provided in proper use of the WRAP. Language in the training manual for use of the WRAP includes ensuring that both the upper and lower body of the juvenile must be controlled before the WRAP is applied. The initial headgear provided to me would not prevent significant injury in the event that loss of control of the upper body occurs. The juvenile I interviewed while I was restrained and with you as witness indicated the use of a separate head protector. This appears to be a motorcycle helmet fully wrapped in duct tape with a cartoonish drawing of eyes, nose and mouth. When applied on me, I found difficulty in breathing and, in turn, increased anxiety. For an individual that is already demonstrating behaviors that reportedly meet criteria in your

center to merit this intervention, this specific head protector is counterproductive. The self report of the youth I interviewed in your presence in addition to the statements provided by other youth in your center indicate some difference in application of the tether strap attaching the harness over the shoulder to the wrap on the legs. As the training manual indicates, this tether should not be over-tightened as it could potentially impact on breathing. Further, I recognize that there are physical limitations in your center. However, other youth being witness to someone in this restraint may be traumatizing in addition to serving to embarrass or otherwise humiliate the individual being restrained. As described earlier, the youth in your center label this process as "torture."

I respect and recognize that your center serves youth with significant behavioral and mental health issues who can become violent and self injurious and demonstrate seemingly callous regard for their own safety and the safety of others. Having tools to address, redress and control these situations are essential. There are pros and cons to the use of any restraint procedure, mechanical or otherwise. I believe the manner in which the WRAP restraint is being used in your center creates significant liability. This is magnified by deficiencies in both policy and documentation. Based on my own experience in this restraint and interviews of youth similarly restrained, it is my opinion that the use of the WRAP restraint on youth is inappropriate. As such, I recommend the following:

- Prohibit the use of the WRAP restraint on all youth in your detention center
- For the Department of Human Services to prohibit the use of the WRAP restraint on all youth in state's custody
- Prohibit the use of the modified helmet and determine a more effective instrument to prevent head injury for youth demonstrating self injurious behaviors
- Revise your policy and procedure manual and incident reporting as described and train your staff accordingly
- Improve capacity to maintain documentation of use of force and other serious incidents in order to track issues and develop strategies to minimize the occurrence of serious incidents in your center
- Employ effective and frequent training for staff in de-escalation techniques such as those through the Crisis Prevention Institute (CPI).

I appreciate your openness and candor regarding these issues. I further recognize that your center offers many services and opportunities that do assist in redirecting young lives. Thank you for your consideration of these initial thoughts. I will continue to explore these concerns with you and other system stakeholders.

Sincerely,

Scott Tanner, Coordinator
Juvenile Ombudsman Division
Arkansas Public Defender Commission

Cc: Keesa Smith, Department of Human Services
Tracy Steele, Division of Youth Services
Herman Williams, Division of Youth Services