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# YOUTH AT RISK

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DANGEROUS RESTRAINTS AND EXCESSIVE  
SECLUSION AT DYRS FACILITIES

November 2023

DISABILITY RIGHTS DC

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Since 1996, Disability Rights DC at University Legal Services, Inc. (“Disability Rights DC”), a private, non-profit legal service agency, has been the federally mandated protection and advocacy (P&A) program for individuals with disabilities in the District of Columbia. As such, Disability Rights DC provides legal advocacy to protect the civil rights of District residents with disabilities and investigates allegations of abuse and neglect.

Disability Rights DC staff directly serves hundreds of individual clients annually, with thousands more benefiting from the results of investigations, institutional reform litigation, outreach, education, and group advocacy efforts. Disability Rights DC staff members address client issues relating to, among other things, abuse and neglect, community integration, inclusion in education, accessible housing, financial exploitation, access to health care services, discharge planning, and the improper use of seclusion, restraint, and medication.

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## EXECUTIVE SUMMARY

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On May 7, 2023, staff at the New Beginnings Youth Development Center (“New Beginnings”),<sup>1</sup> a facility operated by the Department of Youth Rehabilitation Services (“DYRS”), implemented an unauthorized and dangerous restraint of Michael,<sup>2</sup> a 16 year-old boy with a mental health disability, significant trauma history, and asthma.<sup>3</sup> Videotape footage shows an encounter eerily reminiscent of the restraint used to subdue—and subsequently kill—George Floyd.

As discussed in detail in this report, after an initial altercation, five staff persons attempted to force Michael to his room using unauthorized techniques. Staff failed to properly secure Michael, causing two staff persons to fall on him. Michael fell; his head hit the floor. The five staff persons then pinned Michael to the floor, holding his extremities and torso. As Michael struggled to free himself, the staff turned him onto his stomach in a prone position—a very dangerous position. The five staff persons continued to hold Michael down while a large male staff person appeared to place much of his body weight on top of Michael. During this time, the large male staff wrapped his arm around Michael’s neck— another very dangerous intervention. After over two minutes of Michael being held in a prone position, the staff turned Michael onto his back.

Frightened about losing his ability to breathe, Michael struggled to get free. The same large staff person then pushed his forearm directly into Michael’s throat, further endangering Michael’s life. The large male staff then got very close to Michael’s face and appeared to exchange words with Michael while he intermittently shoved his arm further into Michael’s throat. Another staff person then placed a towel over Michael’s face, yet another unauthorized and dangerous intervention. Michael continued to struggle, and the large male staff person appeared to put more weight on Michael’s throat and more of his weight on top of Michael.

Other staff persons then pulled the large staff person off of Michael, at which time the large staff member kicked Michael in the ribs while Michael was restrained and helpless on the floor. The remaining five staff members then pulled Michael to his knees and dragged him to his room. Michael was not only terrified by the event, but he was also physically injured. Michael sustained bite marks on his arm, a finger laceration, a leg injury, and a groin injury. Michael reported that he was fearful for his life during the ordeal, and, like George Floyd, he also felt as though he could not breathe when staff were holding him down and pressing on his neck and throat.<sup>4</sup>

The staff members involved in the restraint used maneuvers that are strictly prohibited by DYRS policies as well as DC law. Prone restraints, such as those used on Michael, are particularly dangerous.<sup>5</sup> Medical experts have asserted that the use of a prone restraint contributed to George Floyd’s death in 2020.<sup>6</sup> Floyd’s tragic death prompted city

governments across the nation—including in DC—to ban dangerous holds.<sup>7</sup> The DC Council recently passed the Comprehensive Policing and Justice Reform Amendment Act of 2022, which prohibits law enforcement from using prone restraints and placing pressure on a person’s neck or throat.<sup>8</sup>

Moreover, staff violated DYRS policy, which allows for physical intervention only when a youth’s behavior threatens imminent harm and permits only the use of approved physical intervention techniques.<sup>9</sup> As described in detail in the next section, the staff involved in the restraint did not follow these legal and policy requirements at multiple intervals throughout the restraint. Their actions were extremely dangerous and put Michael at risk of serious injury or death.<sup>10</sup>

In addition to this disturbing and dangerous restraint, Disability Rights DC discovered a series of abusive seclusion incidents—referred to as “room confinement”—by DYRS staff at the Youth Services Center (“YSC”), another DYRS-operated detention facility. During one incident, staff confined Michael to his room for over eight hours in direct violation of DC law.<sup>11</sup> Disability Rights DC’s monitoring and investigation—along with the work of juvenile justice advocates in the District—also uncovered systemic violations of District law and DYRS policy.<sup>12</sup> Youth have reported to Disability Rights DC that they are often confined to their rooms for hours on end, sometimes for up to 23 hours per day.<sup>13</sup> This practice not only traumatizes the youth, it egregiously violates laws and policies designed to protect them.

The use of seclusion, such as room confinement, and restraint on vulnerable youth, especially children with mental health disabilities, carries a high risk of traumatization and re-traumatization.<sup>14</sup> Research has confirmed that children who are subjected to seclusion and restraint suffer from a reduced ability to learn, an increased chance of resisting teachers and health care providers due to a breakdown in trust, and the loss of a sense of safety.<sup>15</sup> Notably, DYRS’s own policy recognizes the potential for trauma, noting that “isolation and solitary confinement of youth can cause serious psychological, physical, and developmental harm to residents, as well as deleterious effects on youth-staff relationships which ultimately impacts facility safety and security.”<sup>16</sup>

Not only are seclusion and restraint traumatic and degrading, but these practices are also incredibly dangerous. Research shows that seclusion and restraint “can actually fuel violence” creating a cycle in which the use of seclusion and restraint reinforces aggressive behaviors in youth who are secluded or restrained.<sup>17</sup> Children who have experienced physical and sexual abuse are also at increased risk of being re-traumatized by seclusion and restraint.<sup>18</sup>

DYRS must make significant changes to its seclusion and restraint practices and hold staff accountable for their improper use of these interventions. Disability Rights DC makes

critical recommendations at the end of this report that DYRS modify its staffing practices, make its internal policies more comprehensive, and increase the District's oversight measures to ensure its juvenile detention facilities actually promote rehabilitation and healing.

## DANGEROUS RESTRAINT INCIDENT AT NEW BEGINNINGS

In May 2023, Disability Rights DC received a complaint of improper and excessive restraint by DYRS staff of Michael, a 16-year-old resident at New Beginnings. The 10-minute videotape of the incident provides ample evidence of multiple New Beginnings staff conducting an abusive and dangerous restraint. Below is a summary of staff's actions seen on the videotape footage, as well as tracings of still frames of the videotape.<sup>19</sup>

### ANALYSIS OF THE VIDEOTAPE FOOTAGE

The video footage begins with Michael calmly walking toward his room.<sup>20</sup> A staff member holds Michael's door open for him. Michael reported that staff told him to go into his room even though he had 45 minutes left of "floor time" scheduled.<sup>21</sup> He stated that he did not understand why staff were insisting that he go to his room and that staff would not provide an explanation.<sup>22</sup> In the video footage, Michael attempts to push the door closed rather than enter his room.<sup>23</sup>



Michael, pictured in a yellow t-shirt and black pants, pushes the door of his room closed.

Instead of allowing Michael to walk away and thus deescalating the situation, the same staff member who held the door immediately grabs Michael by the arms.<sup>24</sup> Michael attempts to push her away, and another staff member attempts to grab Michael.<sup>25</sup>



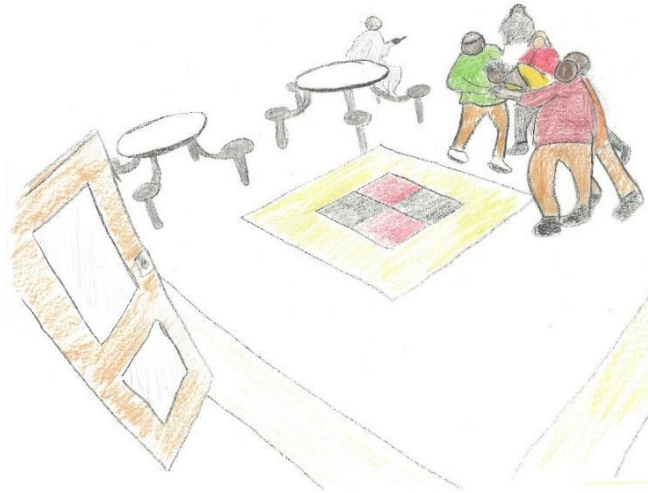
The staff member who held the door open for Michael grabs his left arm. Michael pushes her away as another staff member prepares to intervene.

With his back to the wall, Michael attempts to back away from the three staff members approaching him and then tries to swat their arms away from him as they grab him.<sup>26</sup> The three staff members then move with Michael to the upper right-hand corner of the room.<sup>27</sup> The video footage does not clearly depict what occurs after Michael is pushed into the corner; however, it is clear that multiple staff are attempting to restrain Michael. Michael can then be seen standing and struggling as four staff members hold him in the corner.



Michael moves out of the frame as he moves to the corner with staff. Meanwhile, a staff member uses keys to unlock the door to Michael's room.

The four staff persons do not have Michael in a safe or secure hold. As they are walking Michael back to his room, staff are struggling to secure him. The staff and Michael fall, causing Michael's head to strike hard against the floor while two male staff persons fall on top of Michael – one falls on his head and one falls on his torso.<sup>28</sup>



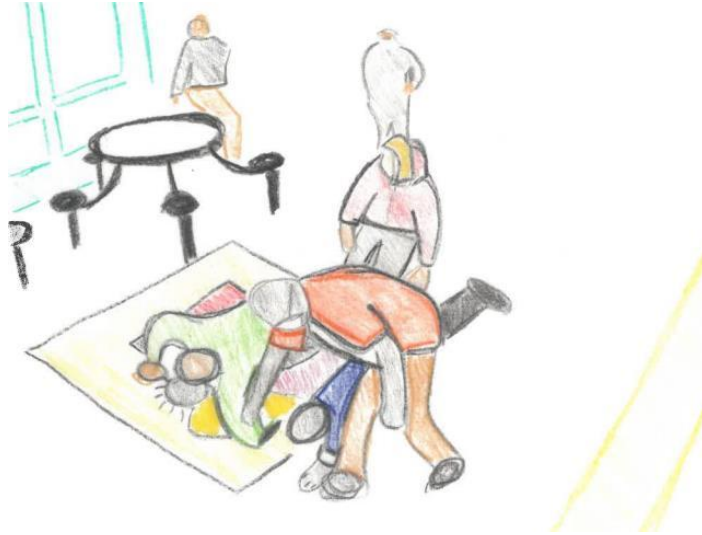
Michael, pictured struggling between four staff members, attempts to move away from the corner.



Staff fail to properly secure Michael as Michael tries to move away. One staff member, depicted in an orange shirt, grabs Michael's collar as Michael falls to the ground, bringing staff with him.



Two staff members then hold Michael at the torso while the other two grab him by his legs.<sup>29</sup> When Michael tries to sit up a staff member shoves him back to the ground.<sup>30</sup>



Michael's head hits the floor with force as staff fall on top of him.



Michael, barely visible underneath the large male staff member, is held down by his torso and legs. The large male staff member rests much of his bodyweight on top of Michael.

Three staff members roll Michael into a prone posture so that he is laying on his stomach, and one large male staff member places much of his weight on Michael's back.<sup>31</sup> The large male staff member simultaneously wraps his left arm around Michael's neck when Michael appears to bite him. The large male staff member reacts by pushing down on top of Michael.<sup>32</sup>



Michael is rolled onto his stomach, in a prone position. The large male staff member places his left arm around Michael's neck.

A staff member who is standing nearby appears to tap the shoulder of the large male staff member who is on top of Michael, seemingly to get him to remove his arm from around Michael's neck.<sup>33</sup> Shortly after removing his arm, the same large male staff member puts his arm back around Michael's neck while keeping much of his body weight on top of Michael.<sup>34</sup>

While he is held to the floor, Michael is struggling and appears to be panicked and very frightened. He later reported that he was having difficulty breathing and was afraid for his life.<sup>35</sup> The large male staff member continues to place much of his body weight on Michael while four staff members hold Michael down.<sup>36</sup> When Michael moves, the large male staff person pushes down on him again with force.<sup>37</sup> At this point, six staff members move Michael so that he is lying on his back again: two are positioned on top of Michael's chest and stomach, two are holding his legs, and another is positioned near his head.<sup>38</sup>



The large male staff member places his weight on Michael's torso, causing Michael to struggle to breathe.

The large male staff person places his weight on Michael's chest and stomach area. He pushes his right arm into Michael's throat.<sup>39</sup> The large male staff appears to be speaking to Michael and is very close to Michael's face. During the conversation, he again shoves his forearm further into Michael's throat.<sup>40</sup> Simultaneously, another staff person places a towel over Michael's entire face, including over his nose and mouth, further restricting his ability to breathe.<sup>41</sup> Staff leave the towel over his face.<sup>42</sup>



A staff member places a towel over Michael's nose and mouth and walks away. The large male staff member simultaneously pushes his elbow into Michael's throat.

Three other staff members then pull the large male staff person off of Michael.<sup>43</sup> The large male staff person stands up—now held back by his colleagues—and **kicks Michael in the ribs** while Michael is helpless and restrained on the floor.<sup>44</sup> The large male staff person then leaves the unit.<sup>45</sup>

Staff move Michael into a prone position again, and five staff persons grab him by his arms and legs, dragging Michael toward his bedroom.<sup>46</sup> Michael falls to his knees and the staff persons drag him into his room. A staff member shuts the door behind him.<sup>47</sup> The video footage concludes with the staff cleaning and adjusting their clothing in the main room while one staff member watches Michael in his room.<sup>48</sup> Throughout the video, staff are seen removing Michael's belongings from his bedroom, including the mattress for his bed.



Michael is dragged into his room by five staff members.

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## REVIEW OF THE MEDICAL RECORDS

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According to the documentation provided to Disability Rights DC, shortly after the restraint incident occurred, a nurse practitioner observed that Michael was “inside his room wearing only his undergarment.”<sup>49</sup> Michael told the provider that during the incident, staff “physically harmed” him and that he was “defending himself because he did not know what the staff was doing to him.”<sup>50</sup> Several hours after the restraint occurred, a registered nurse at New Beginnings documented that Michael sustained an injury to his leg.<sup>51</sup> The following afternoon, a nurse practitioner noted that Michael reported that he was restrained because he refused to go into his room and that he sustained a “faint bite mark on left lower arm,” his left index finger was cut, and he complained of groin pain.<sup>52</sup>

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## REVIEW OF DYRS’S INTERNAL INVESTIGATION

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After reviewing the video footage of Michael’s restraint, Disability Rights DC contacted DYRS and urged the agency to conduct an internal review of the restraint incident, if it had not done so already. DYRS’s Office of Internal Integrity (“OII”) subsequently conducted an investigation and issued a Report of Investigative Findings. As part of its investigation, DYRS interviewed Michael and the staff members involved in his restraint and reviewed, among other things, Michael’s medical records, incident reports, and a logbook entry related to the restraint.<sup>53</sup>

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## NEW BEGINNINGS STAFF VIOLATED DC LAW AND DYRS POLICY

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DYRS staff’s actions were not only dangerous, frightening, and humiliating for Michael, they also violated DC law and DYRS policies. In an important step towards protecting DC residents, the DC City Council recently passed the Comprehensive Policing and Justice Reform Amendment Act of 2022 (“the Act”).<sup>54</sup> The Act prohibits neck restraints and other techniques that can cause asphyxiation.<sup>55</sup> The Act also specifies that law enforcement officers, defined to include DYRS employees,<sup>56</sup> shall not employ “[t]he use of any body part or object by a law enforcement officer against a person with the purpose, intent, or effect of controlling or restricting the person’s airway or severely restricting the person’s breathing”<sup>57</sup> or hold that person “in a position in which that person’s airway is restricted.”<sup>58</sup>

DYRS’s Physical Intervention Policy similarly places strict controls on the use of physical interventions and physical restraint. The policy states that “staff may use physical intervention against a youth only when the youth’s behavior *threatens imminent harm to the youth or others, or to prevent escape, and only after alternative verbal interventions have been exhausted or are impossible*”<sup>59</sup> (emphasis added).

The policy bans the use of certain restraint techniques on youth, including:

- the use of “pressure point control or pain compliance techniques ... restriction of blood circulation or breathing,”<sup>60</sup>
- “throwing youth into a wall or floor,”<sup>61</sup>
- “kicking or striking youth,”<sup>62</sup>
- chokeholds,<sup>63</sup>
- “hogtying youth... or placing youth in restraints in other uncomfortable positions.”<sup>64</sup>

The policy also prohibits “any form of excessive physical intervention, deliberate physical abuse, or physical intervention used as coercion, punishment, or retaliation,”<sup>65</sup> and “use of instruments of restraint prohibited by the DYRS Policy on Use of Restraints.”<sup>66</sup>

Moreover, DYRS policy states that “[i]f use of physical intervention is necessary, staff shall only use approved defensive physical intervention techniques... and only use the amount of force necessary to ensure the safety of youth and others or prevent escape.”<sup>67</sup>

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## STAFF VIOLATIONS

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As described in the videotape footage analysis, DYRS staff’s dangerous actions violated DC law and DYRS policies, including when staff (1) failed to use effective and reasonable de-escalation techniques and instead grabbed Michael by the arms when he did not want to go into his room; (2) surrounded Michael and used an unauthorized technique to escort him to his room, which resulted in Michael falling to the floor and striking his head and staff falling on top of Michael; (3) wrapped their arm around Michael’s neck; (4) pushed an arm into Michael’s throat; (5) placed him in a prone position; and (6) forcibly dragged him to his room.

### STAFF DID NOT HAVE ADEQUATE JUSTIFICATION TO RESTRAIN MICHAEL AND STAFF’S ACTIONS ESCALATED THE SITUATION.

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DYRS staff did not have adequate justification to initiate a physical hold restraint. In an interview with Disability Rights DC, Michael reported that staff ordered him to go to his room before his allotted time on the unit common area was scheduled to end without providing him with an explanation.<sup>68</sup> Documentation indicates that Michael “repeatedly slammed his door shut”<sup>69</sup> prior to staff grabbing his arms. However, as described herein,<sup>70</sup> videotape footage shows Michael walked calmly to his room and tried to close the door; it does not show that Michael slammed his door shut several times, nor does it show that Michael was aggressive or posed a threat to anyone’s safety prior to the staff person grabbing him by the arms. On the contrary, it was the staff’s actions of aggressively grabbing him, followed by more staff surrounding and attempting to grab Michael which appears to have escalated the situation.<sup>71</sup>

## STAFF USED UNNECESSARY FORCE AND UNAUTHORIZED TECHNIQUES TO RESTRAIN MICHAEL .

After the staff person grabbed Michael and he reacted, multiple staff move with Michael into the corner, restrain him, then try to move him to his room. Staff's actions were clearly excessive, extremely dangerous and an unnecessary use of force, all of which are prohibited by DYRS policy. Staff failed to use proper technique when attempting to escort Michael to his room. During the process multiple staff persons and Michael fell to the floor. Michael's head hit the floor. One staff fell on Michael's head; another staff fell on Michael's torso.<sup>72</sup>

Once the restraint of Michael on the floor began, one staff person (referred to as "the large male staff person") appeared to be particularly physically aggressive. As described in the videotape analysis, he wrapped his arm around Michael's neck while Michael was in a prone position. After staff turned Michael over, he pushed his arm into Michael's throat.<sup>73</sup> The DYRS Project Hands Report also found that the videotape footage showed that during the restraint the staff person's "forearm appears to position at [Michael's] neck area with force. [The staff person] is no longer on his right knee and appears to be using his legs to thrust/push forward."<sup>74</sup> The videotape footage also clearly shows staff restraining Michael in a prone position (on his stomach) - thereby restricting his airway - for more than two minutes, which is prohibited by DC law and DYRS policy.<sup>75</sup>

After staff turned Michael on his back, the large male staff person appeared to say something to Michael while very close to Michael's face,<sup>76</sup> at the same time increasing the force of his restraint – so much so that staff had to intervene to remove him from on top of Michael.<sup>77</sup> The DYRS investigation interview of staff confirms this. Staff reported "they began to exchange words, causing [a staff person] to intervene and tap [the large male staff person] out of the restraint."<sup>78</sup> Michael reports that this staff verbally abused him and threatened to kill him while the staff persons were holding him down.<sup>79</sup>

Shockingly, reports from medical staff following the incident state that Michael had bite marks in his skin,<sup>80</sup> and Michael confirms that a staff person bit him during the restraint.<sup>81</sup> The same staff member kicked Michael after being pulled off of Michael by other staff,<sup>82</sup> and he appeared to continue to yell at Michael as other staff escorted him off the unit. Kicking a youth, yelling, or threatening a youth and biting a youth are obviously prohibited interventions.<sup>83</sup> The DYRS investigation report substantiates that the large male staff person violated DYRS's policy against "kicking or striking youth" and "excessive physical intervention, deliberate physical abuse, or physical intervention used as coercion, punishment, or retaliation."<sup>84</sup>

The videotape footage shows after the restraint on the floor, staff physically dragged Michael to his room while Michael was on his knees. The DYRS report found that this was not an authorized technique noting, "there is sufficient evidence to conclude that they

carried [Michael] into his room, using a maneuver/physical intervention, which they did not receive training to apply.”<sup>85</sup>

In addition to the use of excessive physical aggression, staff neglected to consider Michael’s asthma when they held his neck and laid atop his chest. Michael’s asthma is noted throughout his records, and he receives treatment for it from New Beginnings’ medical unit.<sup>86</sup> His asthma, taken together with staff covering Michael’s nose and mouth,<sup>87</sup> laying on top of his stomach and chest throughout most of the incident, and forcing an arm into his neck,<sup>88</sup> combined to create an incredibly dangerous situation. Michael reported to Disability Rights DC that following this incident, he struggled to regain his breath for nearly 30 minutes.<sup>89</sup> Michael’s medical condition—of which staff either were or should have been aware—made the restraint extremely unsafe.

### **STAFF FAILED TO IMPLEMENT LESS RESTRICTIVE ALTERNATIVES PRIOR TO USING A PHYSICAL RESTRAINT.**

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DYRS policy states that the purpose of the policy is to “protect the safety and security of youth... by limiting the use of physical intervention to situations when absolutely necessary.”<sup>90</sup> Therefore, DYRS policy does not allow physical intervention until verbal interventions have been exhausted or are impossible. Although Michael’s records state that he was “counseled by multiple staff extensively”<sup>91</sup> prior to the restraint, the videotape footage contradicts this documentation and does not show that staff engaged in meaningful, deescalating conversation with Michael before they physically grabbed his arms.<sup>92</sup> Staff had many options when Michael told them he did not want to go to his room. For example, staff could have explained the reasons why they wanted him to go to his room prior to Michael’s allotted “floor time” ending, ascertained why he did not want to go to his room, offered the opportunity to call his mother, permitted him some additional time to stay in the unit common area, or simply acknowledged that he did have additional time and allowed him to stay until his allotted time had ended.

### **STAFF FAILED TO ADEQUATELY AND ACCURATELY DOCUMENT THE INCIDENT**

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DYRS policy requires that any staff involved in an incident of physical intervention must complete a written report “describing the incident, the type of force utilized and the necessity for using physical intervention, including attempts to use less restrictive techniques.”<sup>93</sup> However, staff’s documentation of the incident fails to include any description of Michael being taken to and held on the floor, noting only that “staff were able to secure the resident . . .”<sup>94</sup> A restraint such as this—involving multiple staff pinning down a youth and resulting in injuries to the youth—must be accurately documented, reviewed, and evaluated.

The agency’s policy also requires that a detention facility’s management “regularly review all incidents in which physical intervention is used against youth to identify issues needing policy clarification, to develop targeted staff training, and to provide feedback to



staff on effective crisis management.”<sup>95</sup> Failure to accurately document incidents of physical intervention, as occurred here, prevent management’s meaningful review of the incident—review necessary to improving care and safety.

To prevent unnecessary and aggressive incidents of restraint, it is critical that all incidents of physical intervention are closely reviewed by a facility’s administration and management. The investigative report produced by the DYRS Office of Internal Integrity states that it reviewed the incident after receiving a complaint from Disability Rights DC.<sup>96</sup> There is no evidence in the record that indicates DYRS staff reviewed the incident or implemented any corrective measures without first being prompted by an outside entity.

Further, there is nothing in the record to suggest that Michael’s parents or guardians were notified about the violent restraint or Michael’s subsequent injuries. In an interview with Disability Rights DC on Tuesday, May 9, 2023, two days after the restraint incident, Michael’s mother reported that no one from DYRS had contacted her about the violent restraint.<sup>97</sup> She learned about it only after Michael told her during a routine phone call.<sup>98</sup> Current DYRS policy does not require staff to notify parents or guardians when a youth is restrained.

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#### STAFF FAILED TO CONDUCT A DEBRIEFING

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DYRS policy requires that staff and youth involved in an incident of physical intervention “shall undergo an immediate debriefing process with facility management and health staff to explore what might have prevented the need for force and alternative ways of handling the situation.”<sup>99</sup> The records Disability Rights DC received from DYRS do not contain evidence that staff conducted any type of debriefing as the policy requires, thus losing a critical and valuable opportunity for staff to prevent future physical restraints and injuries to both the youth and the staff.

Instead, New Beginnings punished Michael when they issued a Notice of Disciplinary Hearing the day after the incident.<sup>100</sup> The notice inaccurately describes the incident and leaves out key details. The notice states that Michael “became aggressive and assaultive towards staff as he was being asked to secure”<sup>101</sup>—which contradicts the videotape footage—and claims that Michael “remained combative until staff were able to secure the resident.”<sup>102</sup> The Notice fails to describe staff’s violent and abusive restraint. The “Type of Action Taken” field, which includes “physical restraint” as a selection, is left blank.<sup>103</sup>

## ABUSIVE USE OF ROOM CONFINEMENT AT THE YOUTH SERVICES CENTER

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In the months prior to Michael being abusively restrained at New Beginnings, he was also subjected to excessive seclusion at the Youth Services Center (“YSC”), another DYRS detention center located in the District.<sup>104</sup> Furthermore, while investigating this incident, Disability Rights DC became aware of allegations of systemic abusive seclusions at YSC.

Although DYRS authorizes the use of seclusion or “room confinement,” a practice in which youth are—as the name implies—confined to their rooms or “cells,” per policy, this technique is meant to be used only as “a temporary response when a youth’s behavior threatens imminent harm to self or others or threatens the safe or secure operation of YSC or [New Beginnings Youth Detention Center].”<sup>105</sup> Both DC law and DYRS policy place strict limits on the use of room confinement at DYRS facilities. Both allow for room confinement only as a last resort where other, less restrictive measures have failed.<sup>106</sup>

DC law is explicit that juvenile facilities must have adequate justification to confine a youth to their room and cannot use room confinement “for the purposes of discipline, punishment, administrative convenience, retaliation, or staffing shortages.”<sup>107</sup> To protect youth from potential trauma and psychological harm of prolonged room confinement, DYRS policy requires staff to remove the youth from room confinement “[a]s soon as the threat to self or others no longer exists”<sup>108</sup> and both District law and DYRS policy state that seclusion shall not exceed six hours.<sup>109</sup>

### DYRS STAFF CONFINE YOUTH TO THEIR ROOMS FOR UP TO 23 HOURS PER DAY

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As part of its functions as the P&A for the District of Columbia, Disability Rights DC conducts regular monitoring and outreach visits to DYRS facilities. During these visits, Disability Rights DC has observed troubling room confinement practices.

In October 2022, Disability Rights DC observed that all the youth were locked in their rooms at 4:00 PM—an hour when they normally should have been free to move around in the open area on the unit and interact with their peers. In November 2022, YSC staff explained to Disability Rights DC that YSC staff were using a system called “split time,” where only half of the youth on the unit were allowed out of their rooms at a time, and the other youth on the unit were forced to remain in their cells until the other youth had exhausted their time in the common area. In practice, this meant that the youth were confined to their rooms for lengthy intervals.<sup>110</sup> Disability Rights DC noted that several youth appeared frustrated and upset by the excessive time they were confined to their

rooms and were banging on their doors and asking to be let out onto the common area of the unit.

During a July 2023 monitoring visit, YSC staff told Disability Rights DC that it would be difficult to interact directly with the youth because only one youth would be allowed out of their room at a time, and often for only brief periods. This practice also resulted in the time youth spent out of their room being significantly curtailed, as well as interfering with Disability Rights DC's ability to monitor and conduct outreach.

Disturbingly, in December 2022, youth reported to Disability Rights DC that the YSC were being confined to their rooms for *23 hours per day and only allowed out of their cells for one hour*. Allegations of similar abusive room confinement practices in April 2023 were reported in a local media report. According to the DCist, DC's Office of Independent Juvenile Justice Facilities Oversight ("OIJJFO")<sup>111</sup> reported that YSC implemented a facility-wide lockdown which confined all youth to their rooms after an altercation between some of the youth.<sup>112</sup> Disturbingly, this lockdown reportedly lasted for "at least" three days.<sup>113</sup> The OIJFO observed that youth were confined to their rooms for 22 to 23 hours per day and only permitted out "every 10 hours or so."<sup>114</sup> Juvenile justice advocates reported that teachers could only offer youth instruction by "holding up their packets to the window of the cells" and that youth would "have to knock to try and get instruction through a cell door if they have questions."<sup>115</sup>

The DCist article published in July 2023 attributes the excessive room confinement practices to severe staff shortages, noting that DYRS has been "losing staff steadily for the last five years" and "as of this spring, there were almost 30 fewer [staff]" than were there in 2018. The article notes that: "In many cases, that means the facility is staffing units with one [staff] where there used to be two. The agency has also reportedly resorted to using administrative or maintenance staff to fill in for trained [staff]" as the population at the facility has only been increasing.<sup>116</sup>

The above-described alleged incidents of secluding youth clearly violate District law and DYRS policy, which only allows for staff to seclude a youth in room confinement as a last resort where other, less restrictive measures have failed,<sup>117</sup> and not "for the purposes of discipline, punishment, administrative convenience, retaliation, or staffing shortages."<sup>118</sup>

YSC's practice of subjecting youth to this form of solitary confinement can have grave adverse effects, including depression, psychosis, and thoughts of suicide.<sup>119</sup> In fact, DYRS's own policy acknowledges these harms, stating that "isolation and solitary confinement of youth can cause serious psychological, physical, and developmental harm to residents, as well as deleterious effects on youth-staff relationships which ultimately impacts [sic] facility safety and security."<sup>120</sup>

DYRS's alleged failure to adequately staff its facilities poses additional risks to youth safety and wellbeing, especially for youth with mental health disabilities. The OIJFO reported that on several occasions in recent months, DYRS has not had enough staff to provide one-on-one monitoring for youth who are at high suicide risk.<sup>121</sup>

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## DYRS IMPROPERLY SECLUDED MICHAEL ON MULTIPLE OCCASIONS.

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### NOVEMBER 7, 2022, SECLUSION

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In addition to the above-described systemic seclusion practices, Michael was also subjected to excessive seclusion while at YSC. According to YSC records, on November 7, 2022, after a room search and verbal exchange with staff, staff secluded Michael in his room for over eight and a half hours and failed to remove him from seclusion even though he was reportedly calm.<sup>122</sup> The January 2023 Office of Internal Integrity Project Hands investigation of the incident concluded that four staff violated DYRS policy when staff (1) confined Michael to his room for more than six hours, which, as discussed above, per DYRS policy is the maximum amount of time a child can be secluded and, (2) failed to release him as soon as he was calm.<sup>123</sup> Additionally, the Incident Detail Report dated November 7, 2022, failed to describe steps that staff used as meaningful alternative intervention strategies before they placed Michael in room confinement as required by the DYRS policy.<sup>124</sup> Although staff documented that Michael “continue[d] to make threats” as justification for the extended confinement,<sup>125</sup> the January 2023 OII Project Hands investigation of the incident related that, when interviewed, Michael reported that staff grabbed him by the arm and used profanity while ordering him to sit down and threatened to have someone assault him.<sup>126</sup>

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### OTHER INCIDENTS OF SECLUSION (ROOM CONFINEMENT) OF MICHAEL

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In its review of Michael's records, Disability Rights DC noted several instances where Michael was confined to his room but DYRS staff wrongly failed to classify the incident as room confinement or seclusion, and did not follow DYRS policy for room confinement. For example, on August 13, 2022, Michael and other youth were “placed in rooms” as part of a “safety confinement.”<sup>127</sup> On November 22, 2022, staff documented that Michael was “secured” in his room after he was involved in a physical altercation with another youth.<sup>128</sup> However, staff failed to classify these incidents as room confinement or as seclusion. As such, staff failed to adequately document meaningful alternatives that were attempted prior to confining Michael to his room. They also failed to document that they checked on Michael every 15 minutes, nor did they document continued justification for room confinement as required by DYRS policy.<sup>129</sup> As with the restraint incident, there is nothing in the record to indicate that Michael's mother was apprised of her son being repeatedly confined.

As described, YSC room confinement practices violate the rights of youth. Locking children in their rooms can be psychologically damaging and traumatic, as well as illegal. DYRS must ensure that youth are free from such dangerous seclusion practices and hold staff accountable for secluding youth and usings practices that are based on staff convenience, that facilitate administrative policies, that are needed because of staffing shortages, or that are used as punishment.

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## CONCLUSION

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Just as our nation watched in horror as George Floyd was restrained in a dangerous and brutal manner, the videotape footage of Michael's restraint reveals equally disturbing actions by New Beginnings staff. A 16-year-old boy who expressed that he did not want to go into his room, was grabbed and surrounded by multiple staff, fell to the floor—striking his head—while two male staff fell directly on top of him, then pinned him down in a dangerous prone position. When finally turned over, a staff member put his arm around Michael's neck and pushed it into Michael's throat—even after other staff signaled for him to stop—and a towel was placed over his face. A very angry staff member then kicked him in the side. Fortunately, Michael did not die. But he did sustain injuries and perhaps irreparable trauma from the event.

YSC also inflicted trauma when it reportedly confined youth in their cells for up to almost 24 hours per day. While DYRS states that the lockdown lasted for only three days (in itself not permissible), juvenile justice advocates and Disability Rights DC have observed youth being held in their cells at other times. These observations have been confirmed by the youth housed at YSC. Such reckless room confinements put youth at risk of major psychological distress.

DYRS must make significant changes to its current practices if it wishes to provide the service which is in its name: rehabilitation.

## DISABILITY RIGHTS DC'S RECOMMENDATIONS

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DYRS must ensure that all youth in their custody are safe and free from abuse and neglect. DRDC urgently recommends the District take the following actions to prevent future irreparable psychological harm, injury, and even potential death.

**Trauma-Informed Staff Training.** DYRS should require that all New Beginnings staff involved in the restraint incident described in this report and all YSC staff involved in the seclusion incidents described in this report receive in-depth competency-based training on using a trauma informed care approach. DYRS should provide documentation of all completed trainings to Disability Rights DC.

**Policy Overhaul.** DYRS must examine and revise its current policies regarding physical intervention and room confinement of youth at its facilities. DYRS policies at a minimum should include the protection that the Department of Behavioral Health<sup>130</sup> provides to all youth who are in behavioral health facilities, including provisions that address the following:

1. **Youth with trauma histories and disabilities.** As discussed throughout this report, seclusion and restraint have especially adverse impacts on youth who have experienced trauma or have mental health disabilities.<sup>131</sup> DYRS should require that staff consider a youth's medical history, including any mental health diagnoses, and document any contraindications to restraint.
2. **Less restrictive alternatives.** DYRS's Physical Intervention Policy should mandate that staff describe the steps staff used as less restrictive alternatives in staff reports of incidents, and the policy should provide specific examples of the kinds of steps staff should take.<sup>132</sup>
3. **Parental notification.** DYRS's policy should require that staff notify the parent(s) or legal guardian(s) of any youth who has been restrained or secluded and do so within two hours of the initiation or continuation of any restraints or seclusion.<sup>133</sup> DYRS should also make incident reports and other documentation of the seclusion or restraint available to the parent(s) or legal guardian(s) upon request.
4. **Reporting and oversight.** DYRS should include reporting requirements in its Physical Intervention Policy for each of its facilities. Both New Beginnings and YSC should regularly provide data to DYRS and to the public about the number of seclusion and restraint incidents in a given time period at each facility. DYRS should analyze this data to make improvements to its staff

training, mental health treatment for youth, and facility programming.<sup>134</sup>

5. ***Compliance with national standards.*** DYRS’s Physical Intervention Policy states that it aims to “comply with national standards and best practices.”<sup>135</sup> Nonetheless, the policy fails to include widely accepted best practices for restraint and seclusion. DC has promulgated laws limiting the use of seclusion and restraint for youth in facilities that provide mental health services and services for youth with developmental disabilities.<sup>136</sup> In addition, DBH policy requires a debriefing after the incident that includes staff involved, as well as the individual who was restrained.<sup>137</sup>
6. ***Consideration for youth dignity.*** DYRS’s updated seclusion and restraint policies should also specify that staff involved in crisis interventions must work to maintain an individual’s dignity to the maximum extent possible,<sup>138</sup> and these concepts should be incorporated into DYRS policies and practices.

***Regulatory Compliance.*** DYRS must ensure that the facilities it operates adhere to all legal and regulatory requirements related to the treatment of youth. DYRS must provide increased and meaningful oversight of both YSC and New Beginnings. The practice of excessive seclusion of youth must end. DYRS must increase monitoring at these facilities to ensure staff are following all policy and legal requirements when youth are secluded and restrained. For at least three months, DYRS should review videotape footage of all incidents of restraint and randomly review incidents of seclusion to ensure staff adherence to policy and legal requirements. DYRS should provide Disability Rights DC with the results and outcomes of this monitoring and reviews.

***Increase Staffing.*** DYRS must examine its current staff-to-youth ratios at all facilities and increase staffing levels to ensure a safe environment. Minimal staffing ratios – as the OIJFO has observed in its oversight – are not sufficient to keep the units safe.

***Allow for External Monitoring.*** DYRS must allow for Disability Rights DC’s unimpeded access to DYRS facilities so that Disability Rights DC can continue its outreach and monitoring efforts. DYRS must also provide Disability Rights DC with all requested records as required by federal law.

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<sup>1</sup> New Beginnings Youth Development Center is a 60-bed secure facility operated by the DC Department of Youth Rehabilitation Services. The DYRS website states that the focus of New Beginnings is to “[e]mploy interventions that improve our youth’s academic, behavioral, social-emotional, and vocational functioning.” Among the “therapeutic services” provided at New Beginnings are behavioral health services, vocational training and workforce development, and civic and community engagement. DEP’T OF YOUTH REHAB. SERVS., *New Beginnings Youth Development Center*, <https://dyrs.dc.gov/service/new-beginnings-youth-development-center>.

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<sup>2</sup> The name of the youth whose alleged abuse and neglect is the subject of this investigation has been changed to protect his anonymity. “Michael” is used as a pseudonym.

<sup>3</sup> Michael has been diagnosed with several mental health disabilities including unspecified trauma and stressor related disorder, other specified depressive disorder, and specific learning disorder. He also experienced significant trauma when family members were killed by gun violence. See DEP’T OF BEHAV. HEALTH, *Psychiatric Evaluation* at 7-9 (Jul. 15, 2022). Michael also has asthma and receives treatment while in DYRS’s facilities. See *Psychiatric Follow Up* dated May 4, 2023; *Clinical Lists Changes* dated May 6, 2023; *Sick Call Triage* dated May 8, 2023; and *Psychiatric Follow Up* dated May 10, 2023.

<sup>4</sup> Interview with Michael (May 10, 2023).

<sup>5</sup> Placing an individual in a prone restraint compresses their chest cavity and makes it difficult for them to breathe and expel CO<sub>2</sub>, potentially causing prone restraint cardiac arrest. Victor Weedn, Alon Steinberg, & Pete Speth, *Prone restraint cardiac arrest in in-custody and arrest-related deaths*, J. FORENSIC SCI. SEPT.; 67(5), 1899 (2022). Prone restraint can cause “the work of breathing” to become “considerably greater,” which can lead to cardiac arrest and death. *Id.* at 1906.

<sup>6</sup> The prone restraint, the experts found, restricted the flow of oxygen to Floyd’s heart and brain, causing respiration failure. See Steve Karnowski & Tammy Webber, *Lung expert testifies George Floyd died because his breathing was restricted*, AP (Feb. 7, 2022), <https://www.pbs.org/newshour/nation/lung-expert-testifies-george-floyd-died-because-his-breathing-was-restricted>.

<sup>7</sup> D.C. Code § 5-125.03 (2023), § 5-125.02(6); Kimberly Kindy, Michael Schaul, & Ted Mellnik, *Half of the nation’s largest police departments have banned or limited neck restraints since June*. (Sept. 6, 2023), <https://www.washingtonpost.com/graphics/2020/national/police-use-of-force-chokehold-carotid-ban/>

<sup>8</sup> D.C. Code §§ 5-125.02(3), 5-125.02(6), 5-125.03(a)(1) (2023).

<sup>9</sup> DEP’T. OF YOUTH REHAB.SERV., POLICY AND PROCEDURES MANUAL IV.c.3.iii § II.A (2019), [hereinafter DYRS PPM: Use of Physical Intervention].

<sup>10</sup> Prone restraints, such as those used on Michael, are particularly dangerous. See generally Weedn et. al., *supra* Note 5; Karnowski & Webber *supra*, Note 6. See also Scottie Andrew, *The move used to restrain George Floyd is discouraged by most police. Here’s why*, CNN (May 29, 2020), <https://www.cnn.com/2020/05/28/us/george-floyd-knee-to-neck-excessive-force-trnd/index.html>.

<sup>11</sup> D.C. Code § 24-912(e); REPORT OF INVESTIGATIVE FINDINGS FOR PROJECT HANDS CASE # 22-YSC-705 (2023) [hereinafter PROJECT HANDS REPORT YSC-705]; Unusual Incident Report No. 00011610.

<sup>12</sup> While the practice of involuntarily confining a youth alone to an area which the youth is not free to leave is typically referred to as “seclusion,” DYRS refers to this method as “room confinement.” DYRS’s room confinement policy states that the practice is to be used “only as a temporary response when a youth’s behavior threatens imminent harm to self or others or threatens the safe or secure operation of YSC or NBYDC.” DEP’T. OF YOUTH REHAB. SERV., POLICY and PROCEDURES MANUAL IV.c.3.i § (II)(a) (2018) [hereinafter DYRS PPM: Room Confinement]. The stated purpose of the policy is to “restrict[] the use of room confinement and to eliminate the use of disciplinary segregation of youth.” DYRS PPM: Room Confinement at § I.

<sup>13</sup> Disability Rights DC Monitoring Visit, December 2022; Jenny Gathright & Colleen Grablick, *‘Why Is My Child Always On Lockdown?’: Confinement at D.C.’s Youth Jail Worries Parents, Advocates* (Jul. 21, 2023), <https://dcist.com/story/23/07/21/dc-youth-detention-confinement-staffing-crisis/>.

<sup>14</sup> See Denise Marshall, *Trauma-Informed Care: Child Safety Without Seclusion and Restraint*, COUNCIL OF PARENT ATTORNEYS AND ADVOCATES (Dec. 9, 2015), <https://www.copaa.org/blogpost/895540/234517/Trauma-Informed-Care-Child-Safety-Without-Seclusion-and-Restraint>.

<sup>15</sup> *Cf. Id.*

<sup>16</sup> DYRS PPM: Room Confinement, *supra* Note 12 at § II.

<sup>17</sup> Amanda Wik, *Elevating Patient/Staff Safety in State Psychiatric Hospitals*, NAT’L ASSOC. OF STATE MENTAL HEALTH PROG. DIRECTORS RSCH. INST. 1, 4 (Jan. 2018), [https://www.nri-inc.org/media/1465/2018-elevatingpatient\\_endnotesfinal.pdf](https://www.nri-inc.org/media/1465/2018-elevatingpatient_endnotesfinal.pdf). See also Jo Wilton, *Briefing 54: Trauma, Challenging Behaviour and Restrictive Interventions in Schools*, CENTRE FOR MENTAL HEALTH 1, 4 (Jan. 2020), [https://www.centreformentalhealth.org.uk/sites/default/files/2020-01/Briefing\\_54\\_traumainformed%20schools\\_0.pdf](https://www.centreformentalhealth.org.uk/sites/default/files/2020-01/Briefing_54_traumainformed%20schools_0.pdf).



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- <sup>18</sup> Wilton, *supra* note 17, at 7.
- <sup>19</sup> The still frames featured in this report have been traced and sketched to protect Michael’s identity and the identities of the staff members involved in the restraint.
- <sup>20</sup> 20230507\_203548\_(84)\_C84-H2\_Right\_Side.MP4 timed at 8:36:00 PM.
- <sup>21</sup> Interview with Michael (May 10, 2023).
- <sup>22</sup> *Id.*
- <sup>23</sup> 20230507\_203548\_(84)\_C84-H2\_Right\_Side.MP4 timed at 8:36:12 PM.
- <sup>24</sup> *Id.* timed at 8:36:14 PM.
- <sup>25</sup> *Id.* timed at 8:36:15 PM.
- <sup>26</sup> *Id.* timed at 8:36:18 PM.
- <sup>27</sup> *Id.* timed at 8:36:24 PM.
- <sup>28</sup> 20230507\_203548\_(84)\_C84-H2\_Right\_Side.MP4 timed at 8:38:12 PM.
- <sup>29</sup> *Id.* timed at 8:38:15 PM.
- <sup>30</sup> *Id.* timed at 8:38:26 PM.
- <sup>31</sup> *Id.* timed at 8:38:37 PM-8:39:29 PM.
- <sup>32</sup> *Id.* timed at 8:38:51-54 PM.
- <sup>33</sup> *Id.* timed at 8:38:56 PM.
- <sup>34</sup> 20230507\_203548\_(84)\_C84-H2\_Right\_Side.MP4 timed at 8:39:05 PM.
- <sup>35</sup> Interview with Michael (May 10, 2023).
- <sup>36</sup> 20230507\_203548\_(84)\_C84-H2\_Right\_Side.MP4 timed at 8:39:11 PM.
- <sup>37</sup> *Id.*
- <sup>38</sup> *Id.* timed at 8:40:50 PM.
- <sup>39</sup> *Id.* timed at 8:40:54 PM.
- <sup>40</sup> *Id.* timed at 8:41:50 PM.
- <sup>41</sup> 20230507\_203548\_(84)\_C84-H2\_Right\_Side.MP4 timed at 8:41:54 PM.
- <sup>42</sup> *Id.* to 8:42:07.
- <sup>43</sup> *Id.* timed at 8:41:59 PM.
- <sup>44</sup> *Id.* timed at 8:42:08 PM.
- <sup>45</sup> *Id.* timed at 8:42:20 PM.
- <sup>46</sup> 20230507\_203548\_(84)\_C84-H2\_Right\_Side.MP4 timed at 8:42:44 PM.
- <sup>47</sup> *Id.* timed at 8:43:02 PM.
- <sup>48</sup> *Id.* timed at 8:44:26 PM.
- <sup>49</sup> Mental Health Consultation: MH Consultation, entered at 12:19 AM (May 8, 2023).
- <sup>50</sup> *Id.*
- <sup>51</sup> Incident Assessment Report, entered at 5:59 AM (May 8, 2023).
- <sup>52</sup> Incident Assessment Report, entered at 3:52 PM (May 8, 2023).
- <sup>53</sup> REPORT OF INVESTIGATIVE FINDINGS FOR PROJECT HANDS CASE # 23-NB-731 (Aug. 8, 2023) [hereinafter PROJECT HANDS REPORT NB-731].
- <sup>54</sup> Comprehensive Policing and Justice Reform Amendment Act of 2022, D.C. Code § 5-125.01 *et seq.* (effective date April 21, 2023).
- <sup>55</sup> D.C. Code §§ 5-125.02(6); 5-125.03(a)(1).
- <sup>56</sup> D.C. Code § 5-125.02(4)(F).
- <sup>57</sup> D.C. Code § 5-125.02(3)(A).
- <sup>58</sup> D.C. Code § 5-125.02(3)(B).
- <sup>59</sup> DYRS PPM: Use of Physical Intervention, *supra* Note 9 at § II.A.
- <sup>60</sup> DYRS PPM: Use of Physical Intervention, *supra* Note 9 at § VI.B.a.
- <sup>61</sup> DYRS PPM: Use of Physical Intervention, *supra* Note 9 at § VI.B.b.
- <sup>62</sup> DYRS PPM: Use of Physical Intervention, *supra* Note 9 at § VI.B.b.
- <sup>63</sup> DYRS PPM: Use of Physical Intervention, *supra* Note 9 at § VI.B.c.
- <sup>64</sup> DYRS PPM: Use of Physical Intervention, *supra* Note 9 at § VI.B.d.

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- <sup>65</sup> DYRS PPM: Use of Physical Intervention, *supra* Note 9 at § VI.B.e.
- <sup>66</sup> DYRS PPM: Use of Physical Intervention, *supra* Note 9 at § VI.B.f.
- <sup>67</sup> DYRS PPM: Use of Physical Intervention, *supra* Note 9 at § VI.A.
- <sup>68</sup> Interview with Michael (May 10, 2023).
- <sup>69</sup> Notice of Disciplinary Hearing, Incident No. 00012572 (May 8, 2023).
- <sup>70</sup> *See* n. 20; 20230507\_203548\_(84)\_C84-H2\_Right\_Side.MP4 timed at 8:36:05 PM.
- <sup>71</sup> The August 8, 2022 Project Hands Investigation by the DYRS OII also does not provide evidence that Michael was an imminent threat. To the contrary, the report notes that “[Michael] attempted to close the door again but was unsuccessful... then tried to close the door forcefully, causing [the staff] to respond by attempting to place [Michael] in an SCM maneuver.” Although the report does not specify what an “SCM maneuver” consists of, it presumably was the action of the staff grabbing Michael as seen in the videotape footage. The report does not provide any justification for staff’s actions of physically grabbing a youth because the youth attempted to close a door, even if done “forcefully.” PROJECT HANDS REPORT NB-731, *supra* Note 53 at 19.
- <sup>72</sup> 20230507\_203548\_(84)\_C84-H2\_Right\_Side.MP4 timed at 8:38:12 PM.
- <sup>73</sup> *See* 20230507\_203548\_(84)\_C84-H2\_Right\_Side.MP4, *supra* notes 34, 39, 40.
- <sup>74</sup> PROJECT HANDS REPORT NB-731, *supra* Note 53 at 16.
- <sup>75</sup> D.C. Code § 5-125.02(3)(B); DYRS PPM: Use of Physical Intervention, *supra* Note 9 at § VI.B.a.
- <sup>76</sup> *See* n. 40.
- <sup>77</sup> *See* n. 43.
- <sup>78</sup> PROJECT HANDS REPORT NB-731, *supra* Note 53 at 4.
- <sup>79</sup> Michael reported that the staff member called him a “little bitch ass” and said “I’m gonna kill you.” Interview with Michael (May 10, 2023). In an interview with the Office of Internal Integrity, the large male staff member who was lying directly on top of Michael and put his arm around Michael’s neck admitted that he was “tired and upset when [the youth] again spat and clamped onto his arm” while executing the restraint. PROJECT HANDS REPORT NB-731, *supra* Note 53 at 9.
- <sup>80</sup> *See* n. 52.
- <sup>81</sup> Interview with Michael (May 10, 2023).
- <sup>82</sup> *See* n. 44, 20230507\_203548\_(84)\_C84-H2\_Right\_Side.MP4 timed at 8:42:08
- <sup>83</sup> *See* n. 59 – 66.
- <sup>84</sup> DYRS PPM: Use of Physical Intervention, *supra* Note 9 at §§ II.B, VI.B.b, VI.B.e; PROJECT HANDS REPORT NB-731, *supra* Note 53 at 1, 23. In addition, the Project Hands Report states that the staff members involved in the restraint violated Section VI.B.g of the Physical Intervention Policy, which prohibits any “unapproved form of physical intervention or intervention which staff have not received training to apply.” It is not clear whether this violation is in reference to staff’s inappropriate carrying of Michael into his room or to placing the towel over Michael’s face. (The staff member who placed the towel over Michael’s face told the OII that they did so for “precautionary reasons” and that they thought “the towel was the best tool available to protect the health/safety of everyone at the time.” PROJECT HANDS REPORT NB-731, *supra* Note 53 at 6. The Report also states that the large male staff member who laid atop Michael violated the sections of the policy that prohibit “hitting youth with a closed fist, throwing youth into a wall or floor, pulling a youth’s hair, or kicking or striking youth, including blows to the head” and “any form of excessive physical intervention, deliberate physical abuse, or physical intervention used as coercion, punishment, or retaliation.” The large male staff member also violated DYRS’s Employee Conduct Policy. PROJECT HANDS REPORT NB-731, *supra* Note 53 at 23.
- <sup>85</sup> PROJECT HANDS REPORT NB-731, *supra* Note 53 at 22.
- <sup>86</sup> *See* *Psychiatric Follow Up* dated May 4, 2023; *Clinical Lists Changes* dated May 6, 2023; *Sick Call Triage* dated May 8, 2023; and *Psychiatric Follow Up* dated May 10, 2023.
- <sup>87</sup> *See* 20230507\_203548\_(84)\_C84-H2\_Right\_Side.MP4, *supra* notes 42, 42.
- <sup>88</sup> *See* 20230507\_203548\_(84)\_C84-H2\_Right\_Side.MP4, *supra* notes 32-34, 40.
- <sup>89</sup> Interview with Michael (May 10, 2023).
- <sup>90</sup> DYRS PPM: Use of Physical Intervention, *supra* Note 9 at § I.
- <sup>91</sup> Notice of Disciplinary Hearing, Incident No. 00012572 (May 8, 2023).

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- <sup>92</sup> See n. 23 – 24; 20230507\_203548\_(84)\_C84-H2\_Right\_Side.MP4 timed at 8:36:13 PM.
- <sup>93</sup> DYRS PPM: Use of Physical Intervention, *supra* Note 9 at § VI.D.
- <sup>94</sup> Notice of Disciplinary Hearing, Incident No. 00012572 (May 8, 2023).
- <sup>95</sup> DYRS PPM: Use of Physical Intervention, *supra* Note 9 at § VI.E.
- <sup>96</sup> Project Hand Report NB-731 at page 1.
- <sup>97</sup> Interview with Michael’s Mother (May 9, 2023).
- <sup>98</sup> Interview with Michael’s Mother (May 9, 2023).
- <sup>99</sup> DYRS PPM: Use of Physical Intervention, *supra* Note 9 at § VI.E.
- <sup>100</sup> Notice of Disciplinary Hearing (May 8, 2023).
- <sup>101</sup> *Id.*
- <sup>102</sup> *Id.*
- <sup>103</sup> *Id.*
- <sup>104</sup> YSC is described by DYRS as the District of Columbia’s detention center for male and female youth. It is an 88-bed secure facility where youth are provided “direct and continuous observation, supervision, and on-the-spot counseling.” Importantly, DYRS states that two staff members are always assigned to each housing unit. *Youth Services Center*, DC DEP’T OF YOUTH REHAB. SERV., <https://dyrs.dc.gov/service/youth-services-center>.
- <sup>105</sup> DYRS PPM: Room Confinement, *supra* Note 12 at § II.a.
- <sup>106</sup> D.C. Code § 24-912(b)(2); DYRS PPM: Room Confinement, *supra* Note 12 at § VI.A.
- <sup>107</sup> D.C. Code § 24-912(a).
- <sup>108</sup> DYRS PPM: Room Confinement, *supra* Note 12 at § II.b.
- <sup>109</sup> DYRS PPM: Room Confinement, *supra* Note 12 at § II.b; D.C. Code § 24-912(e).
- <sup>110</sup> Disability Rights DC Monitoring (Jul. 2023). During this visit to YSC, DYRS staff explained that “split time” was in effect because youth were “beefing” with one another.
- <sup>111</sup> As part of a consent decree in a class action lawsuit filed in 1985, Jerry M., et al. v. District of Columbia, et al., juvenile justice facilities in the District of Columbia were subject to court oversight and monitoring until December 2020. While the consent decree has since ended, DYRS created an entity called the Office of Independent Juvenile Justice Oversight. The Office regularly publishes reports on topics such as staffing and the presence of Covid-19 in the District’s juvenile justice facilities and has unfettered access to the facilities. *Mayor Bowser Announces the End of Court Oversight of the DC Department of Youth Rehabilitation Services*, DC DEP’T OF YOUTH REHAB. SERV., <https://dyrs.dc.gov/release/mayor-bowser-announces-end-court-oversight-dc-department-youth-rehabilitation-services>.
- <sup>112</sup> Jenny Gathright & Colleen Grablick, ‘*Why Is My Child Always On Lockdown?’: Confinement at D.C.’s Youth Jail Worries Parents, Advocates* (Jul. 21, 2023), <https://dcist.com/story/23/07/21/dc-youth-detention-confinement-staffing-crisis/>.
- <sup>113</sup> *Id.*
- <sup>114</sup> *Id.*
- <sup>115</sup> *Id.*
- <sup>116</sup> *Id.*
- <sup>117</sup> D.C. Code § 24-912(b)(2); DYRS PPM: Room Confinement, *supra* Note 12 at § VI.A.
- <sup>118</sup> D.C. Code § 24-912(a).
- <sup>119</sup> Joseph Calvin Gagnon, *The solitary confinement of incarcerated American youth during COVID-19*, Psych. Res. 291 (Jun. 2020), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7286258/>.
- <sup>120</sup> DYRS PPM: Room Confinement at § II.
- <sup>121</sup> Jenny Gathright & Colleen Grablick, ‘*Why Is My Child Always On Lockdown?’: Confinement at D.C.’s Youth Jail Worries Parents, Advocates* (Jul. 21, 2023), <https://dcist.com/story/23/07/21/dc-youth-detention-confinement-staffing-crisis/>.
- <sup>122</sup> PROJECT HANDS REPORT YSC-705, *supra* Note 11 at 10, 12.
- <sup>123</sup> PROJECT HANDS REPORT YSC-705, *supra* Note 11 at 13–14.
- <sup>124</sup> See DYRS PPM: Room Confinement, *supra* Note 12 at § VI.A.
- <sup>125</sup> PROJECT HANDS REPORT YSC-705, *supra* Note 11 at 7.

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<sup>126</sup> PROJECT HANDS REPORT YSC-705, *supra* Note 11 at 2.

<sup>127</sup> Incident Report, Document Control Number: 08220220813210918834, dated Aug. 13, 2022.

<sup>128</sup> Incident Report, Document Control Number: 08220221122212619022, dated Nov. 22, 2022.

<sup>129</sup> *See generally* DYRS PPM: Room Confinement.

<sup>130</sup> For example, the DC Department of Behavioral Health requires that mental health providers must assess and identify children “who have experienced physical, psychological, or sexual trauma, including abuse, and those at high risk for seclusion and restraint events for any reason” and that “the assessment shall include a review of the child or youth’s medical condition and any disability.” *See* D.C. Mun. Regs. tit. 22-A § 515.4 (2005). While Michael’s records note that he has been exposed to community violence and has an extensive trauma history, current policy and practice does not require such an assessment be considered prior to restraining a youth.

<sup>131</sup> DYRS served an estimated 1,550 youth during FY 2019. DC DEP’T OF YOUTH REHAB. SERV., FY 2019 ANNUAL REPORT 15 (2019),

[https://dysr.dc.gov/sites/default/files/dc/sites/dysr/page\\_content/attachments/AnnualReportFY2019Web\\_0.pdf](https://dysr.dc.gov/sites/default/files/dc/sites/dysr/page_content/attachments/AnnualReportFY2019Web_0.pdf).

While DYRS’ latest annual report does not include data regarding the number of committed youth with disabilities, other organizations estimate that between 65 and 70% of youth who enter the juvenile justice system have an emotional or developmental disability. *See* COALITION FOR JUVENILE JUSTICE, YOUTH WITH UNDIAGNOSED OR MISTREATED DISABILITIES, <https://www.juvjustice.org/our-work/safety-opportunity-and-success-project/national-standards/section-i-principles-responding-2>; NATIONAL CENTER ON CRIMINAL JUSTICE AND DISABILITY, JUSTICE-INVOLVED YOUTH WITH INTELLECTUAL DEVELOPMENTAL DISABILITIES: A CALL TO ACTION FOR THE JUVENILE JUSTICE COMMUNITY, [http://thearc.org/wp-content/uploads/2019/07/15-037-Juvenile-Justice-White-Paper\\_2016.pdf](http://thearc.org/wp-content/uploads/2019/07/15-037-Juvenile-Justice-White-Paper_2016.pdf).

<sup>132</sup> DYRS’s policy states that physical intervention should be used “only after alternative verbal interventions have been exhausted or are impossible.” DYRS PPM: Use of Physical Intervention, *supra* Note 9 at § II.A. DYRS must incorporate additional techniques into its policy. In the incident reports following Michael’s restraint, staff recorded that they verbally “counseled” Michael repeatedly. This “counseling,” however, was clearly insufficient. The policy should demand that staff exhaust a series of other less restrictive alternatives before physically restraining a youth. Such tactics might include reduction of stimuli surrounding the youth, negotiation, or redirection. To prevent future instances of unnecessary seclusion and restraint, staff should also be required to create positive intervention plans for youth. *See* D.C. Mun. Regs. tit. 22-A § 515.7. These positive behavior plans should be created with input from the youth and include less restrictive alternatives to seclusion and restraint that the youth believes may be effective.

<sup>133</sup> The Department of Behavioral Health has similar requirements for reporting instances of seclusion and restraint to parents. *See* D.C. Mun. Regs. tit. 22-A § 518.1. The DCMR also dictates that staff must document contact and attempted contact with the youth’s parent or legal guardian.

<sup>134</sup> The Department of Behavioral Health requires that mental health providers report incidents of seclusion and restraint to demonstrate compliance with federal rules and regulations. *See* D.C. Mun. Regs. tit. 22-A §§ 520.1-520.6.

<sup>135</sup> DYRS PPM: Use of Physical Intervention, *supra* Note 9 at § II.

<sup>136</sup> *See generally* D.C. Mun. Regs. tit. 22-A § 515.

<sup>137</sup> D.C. Mun. Regs. tit. 22-A §§ 510.1–510.2.

<sup>138</sup> *See generally* Beata Backstrom, Bjorn Axel Johansson, Charlotta Perers, and Olof Rask, *Methods and Strategies for Reducing Seclusion and Restraint in Child and Adolescent Psychiatric Inpatient Care*, PSYCH. Q. 93(1) (2022), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8993718/>. As an example, the Department of Behavioral Health requires mental health providers to use interventions with “consideration and respect for the consumer’s dignity, autonomy and privacy at all times.” D.C. Mun. Regs. tit. 22-A § 502.1. Consideration for Michael’s dignity, autonomy, and privacy were notably lacking here, as evidenced by staff’s excessive physical force, yelling at him, threatening him, kicking him, and biting him.