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June 30, 2020

The Honorable Andrew M. Cuomo
Governor of New York State
NYS State Capitol Building
Albany, NY 12224

Commissioner Sheila Poole
NYS Office of Children and Families
52 Washington Street
Rensselaer, NY 12144

Dear Governor Cuomo and Commissioner Poole:

While we commend New York State for enacting a ban on the use of chokeholds by law enforcement, New York State's children living in Residential Treatment Centers (RTCs)[1] face a similar threat of death or serious injury at the hands of staff that must be addressed. Children in foster care placed in RTCs, facilities overseen by the New York State Office of Children and Family Services (OCFS), are subject to "prone" or face-down restraints. **These restraints are prohibited in virtually every other residential child care facility in NYS because they are known to risk death or serious harm.** This dangerous practice must be ended now.

Recent events have tragically brought to the fore the need for immediate reform. On May 1, 2020, 16 year old Cornelius Frederick died of cardiac arrest following a physical restraint where multiple staff placed their weight on the teen's chest, abdomen and legs at a residential placement in Michigan. Michigan Governor Whitmer revoked the facility's license, and took the bold step of prohibiting the use of *all* physical restraints in of Michigan's licensed child care facilities.

Last week it was reported that in Arizona, a 27 year old man died from a combination of physical restraint and cardiac arrest involving cocaine intoxication in the course of a prone restraint.[2] As the New York Times reported, "[f]or years, many departments have trained officers that people held face down, in what is known as 'prone restraint,' are more likely to die suddenly of positional asphyxia because they have difficulty expanding their chest to bring in air."

Similar, appalling tragedies have occurred in NYS as several children in the care of OCFS or under its supervision have died or suffered catastrophic injuries from prone restraints. In April, 2019, a developmentally delayed New York City foster child in an RTC suffered devastating and catastrophic injuries, including quadriplegia, after reportedly being subjected to a prone restraint. In

[1] When we use the term "RTCs," we include both the general and specialized residential programs operated by JCCA, Children's Village, Graham Windham, Mercy First, St. John's, Jewish Board of Children and Family Services, and SCO on their RTC campuses. At JCCA, for example, this includes both Edenwald and Gateways. At Children's Village, this includes the programs to address problematic sexualized behavior.
[2] https://www.nytimes.com/2020/06/24/us/tucson-arizona-police-death.html?referringSource=articleShare.

2012, a 16-year-old boy with special needs died after being subjected to a prone restraint by four staff members at an OCFS licensed RTC. In 2006, a young teen from the Bronx died after being held in a prone restraint on the bathroom floor by multiple staff at an OCFS operated juvenile justice facility.[3] Finally, a 14-year-old boy suffer[ed] serious and permanent physical and mental injuries following successive prone restraints by OCFS staff in 1996 at an OCFS juvenile justice facility.[4] Such cruelty and depravity has no place in the child "welfare" system.

Nor can these tragedies be dismissed as the result of bad actors or poor training. Just as police brutality is tied to racist institutions, so is the practice of using force against children in residential institutions. This is especially true in New York State --where appalling and longstanding racial disparities exist in the child welfare system. Black and Latinx children enter the child welfare system in numbers far greater than their proportion of the general population.[5] In keeping with these disparities, foster children placed in residential institutions are predominantly Black (~58%) and Hispanic (~30%).[6] For children placed in RTCs, the trauma of removal from their families is then compounded by the trauma of being subjected to brutal and dangerous restraint practices.

Prone restraints are impermissible in virtually every other residential setting in New York State. The NYS Office of Mental Health (OMH), the NYS Office for People with Developmental Disabilities (OPWDD) and NYC's Administration for Children's Services Children's Center all prohibit the use of prone restraints.[7] OCFS' own Division of Juvenile Justice and Opportunities for Youth (DJJOY) and ACS's Division of Youth and Family Justice also prohibit the use of prone restraints on children in residential care, except as a transitional hold for a maximum of three minutes.[8] Several states and federal agencies also ban prone restraints. In its guidance to state education departments, the federal Department of Education warns that "[p]rone restraints should never be used because they can cause serious injury or death."[9]

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[3] Thompson v. Johnson et al., 6:08-CV -01241 (NDNY).

[4] Jackson v. Johnson, 118 F. Supp. 2d 278, 283-85 (NDNY 2000).

[5] Black children enter the child welfare system in numbers far greater than their proportion of the general population. While Black children represent 24.3% of New York City's youth, they make up over 55% of the population in foster care. In New York City, Black children are 6.2 times as likely to be reported to States Central Registry for child abuse compared to white children, 7.8 times as likely to be indicated, 12.8 times as likely to be admitted to foster care, and 13.3 times as likely to be in care, according to 2014 OCFS data. Hispanic children in NYC are likewise more likely to be involved in the child welfare system when compared to their white contemporaries; Hispanic youth in NYC are 5.4 times as likely to be involved in an indicated case, 5.6 times as likely to be admitted to foster care, and 5.4 times as likely to be in care. https://ocfs.ny.gov/main/bcm/DMR_Section%20Seven%20of%20Grant%20RFP_2015.pdf.

[6] The Center for State Child Welfare Data: Evaluation of New York City's Administration for Children's Services' Residential Care Services Array, Chapin Hall, February 2020.

[7] New York State Office of Mental Health, Official Policy Manual Directive, PC-201, "Seclusion and Restraint," 5/15/2017; 14 NYCRR §§ 624, 625; OPWDD Handbook (2017) at 15; 14 NYCRR §§ 624, 625; New York State Education Department abides by State and Federal Guidelines and the Federal Department of Education's 2012 "Restraint and Seclusion: Resource Document."

[8] See OCFS Policy and Procedures Manual, PPM 3247.12, Crisis Prevention and Management; 14 NYCRR §§ 624, 625

[9] U.S. Department of Education Restraint and Seclusion: Resource Document (May 2012) p. 16.

Nonetheless, OCFS specifically permits RTCs it is responsible for licensing to use prone restraints, even though such restraints are more likely to result in serious harm or death than other types of restraint.[10] A prone restraint involves staff forcing the child to the ground and holding them there in a face down position. Prone restraints expose children to increased risks of positional asphyxiation, obstructed breathing, cardiac and respiratory arrest, back, arm and neck injuries, abrasions, bruises, strained muscles and other musculoskeletal injuries, and head injuries. Prone restraints can cause suffocation by compressing the child's ribs preventing the chest cavity from expanding, and pushing the abdominal organs up restricting the diaphragm and reducing the room for lung expansion.[11]

The Legal Aid Society's Juvenile Rights Practice represents the vast majority of children in New York City's foster care system under the auspices of the Administration for Children's Services (ACS). Many of our clients reside in congregate care facilities including the RTCs at issue here, some as young as seven years old. These clients regularly report being subjected to the trauma of unnecessary physical restraints and excessive force, including prone restraints. We are appalled that that NYS permits staff to use prone restraints on children in RTC care and we have been urging both ACS and OCFS to end the dangerous use of prone restraints in RTCs for years.

OCFS' refusal to impose a ban on prone restraint use on foster children in RTCs is especially confounding considering that it has severely restricted their use on children in its DJJOY facilities in response to litigation filed separately by the U.S. Department of Justice, and The Legal Aid Society and Orrick, Herrington & Sutcliff LLP, respectively. When the U.S. Department of Justice investigated OCFS's facilities for its unlawful use of restraints, it warned in its "Findings Letter" in 2009:

> Even when staff are following approved practices, restraints can be dangerous. In particular, the use of prone restraints is controversial and has been banned by many facilities nationwide due to the high risk of serious injury or death. In spite of the known risk of prone restraints, staff at the facilities are trained to use prone restraints. **The danger of prone restraints is that if the individual's airway is constricted, he or she is unable to express physical distress. Further, the restrained individual's struggle for air may be misconstrued by staff as resistance, resulting in increased force on the restrained individual.** Indeed, in November 2006, a 15-year-old resident at Tryon Boys died following a prone restraint. The youth allegedly pushed

[10] OCFS contracts with Therapeutic Crisis Intervention (TCI), a crisis prevention and intervention program developed by Cornell University, to provide training for staff at OCFS licensed foster care congregate facilities. While TCI offers training in an array of restraint techniques less restrictive than prone, OCFS's contract generally limits trainings to the use of small child, standing and prone restraints. *See* Leslie Morrison, *The Lethal Hazard of Prone Restraint: Positional Asphyxiation*, at 17-23 (Protection and Advocacy, Inc.: 2002), http://www.disabilityrightsca.org/pubs/701801.pdf.

[11] Disability Rights California, "The Lethal Hazard of Prone Restraint: Positional Asphyxiation 17-18 (2002); see also NDRN, "School is Not Supposed to Hurt" at 13 ("Studies and organizations, including the Joint Commission on Accreditation of Healthcare Organizations, have concluded that prone restraint may predispose a patient to suffocation.").

> a staff member and was then pinned face-down on the floor and handcuffed by two staff. The youth stopped breathing only minutes later, and then died at a nearby hospital. His death was ruled a homicide by the medical examiner. Despite this tragic death, a dangerous combination of high rates of prone restraints and a low standard for initiating a restraint remains at the facilities.[12] (Emphasis added).

Yet, more than a decade later, OCFS continues to authorize the use of prone restraints in RTCs, treatment programs designed to serve primarily abused and neglected children in the child welfare system. [13]

Nothing contained in this letter is new to New York State. In fact, in 2007, OCFS participated in the Counsel on Children and Families' Restraint and Crisis Intervention Technique Committee (Restraint Committee), charged with examining the crisis intervention approaches used by four state agencies serving children in New York – OCFS, OMH, OPWDD, and the NYS Education Department. The Restraint Committee recommended that all four agencies adopt a uniform technique that would not include prone restraints. Due to OCFS intransigence, the Restraint Committee's recommendations were never realized.[14]

Action to prohibit the dangerous use of prone restraints in Residential Treatment Centers is overdue. We urge New York State to do so before any more children are harmed or killed by this practice.

Sincerely,

DAWNE A. MITCHELL

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[12] U.S. Dept. of Justice Findings Letter regarding four New York juvenile facilities, August 14, 2009, p. 10. https://www.justice.gov/sites/default/files/crt/legacy/2010/12/15/NY_juvenile_facilities_findlet_08-14-2009.pdf.

[13] While focused on RTCs here, our concerns regarding restraint practices and oversight extend to all facilities in which ACS places children that are authorized by OCFS to use physical restraints.

[14] New York State Office of Mental Health, Official Policy Manual Directive, PC-201, "Seclusion and Restraint," 5/15/2017; 14 NYCRR §§ 624, 625; OPWDD Handbook (2017) at 15; 14 NYCRR §§ 624, 625; SED abides by State and Federal Guidelines and the Federal Department of Education's 2012 "Restraint and Seclusion: Resource Document."