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SWAN VALLEY YOUTH ACADEMY
INVESTIGATIVE REPORT

CHILD AND FAMILY SERVICES DIVISION
MONTANA DPHHS

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SWAN VALLEY YOUTH ACADEMY INVESTIGATIVE REPORT

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I. INTRODUCTION

Swan Valley Youth Academy (SVYA) is owned and operated by Cornerstone Programs Corporation based in Colorado, and has been licensed as Child Care Agency with the designation Residential Treatment Center since February 2000. A residential treatment center provides substitute care for 13 or more children and treats children that are seriously disturbed, either mentally, emotionally or behaviorally. The facility contracts for placements with the Federal Bureau of Prisons, individual Montana Indian tribes, and with individual Judicial Districts for placement of delinquent youth. Additionally, the facility currently has one youth placed privately by his parent. SVYA is often considered an alternative placement to incarceration, and is presented to many youth as their "last chance" before being incarcerated.

Child and Family Services Division received written referrals on November 4, 2005, regarding allegations of child abuse and neglect of youth involved in the Swan Valley Youth Academy. The initial referrals involved seven named youth and implied that all youth placed in the program were at risk of child abuse and neglect. Subsequent referrals called into CFSD and other referrals that have arisen during the investigative process increased the number of youth and incidents that were investigated.

II. INVESTIGATION PROCESS

The Child and Family Services Division investigation began on November 4, 2005, after which a more thorough joint investigation was initiated with the Lake County Sheriff's Department and the DPHHS Quality Assurance Division (licensing) at the request of the Lake County Attorney's office. Over the next six weeks, the investigation uncovered additional concerns regarding numerous youth placed at the facility. The investigative process involved the following:

- Case File Reviews
- Interviews with youth currently placed at the facility (21 youth)
- Interviews with who were previously placed at the facility (6 youth)
- Interviews with Current staff members (13 staff)
- Interviews with Previous staff members (7 staff)
- Walk through of the main building of the facility
- Observing youth/staff interactions while at the facility
- Review of pertinent policy and procedures (limited)
- Phone contact and meeting with Cornerstone CEO Joe Newman
- Phone contact with placing agency personnel
- Review of personnel files (limited)
- Interviews with parent of youth (2 parents)

- Dates investigators were on the SVYA campus were November 4, 7-10, 17-18, 23, and December 7 &16, 2005.
- Observation of a youth intake utilizing a 'new' intake process on December 16, 2005.

Factors that made the investigation more difficult were the following:

- Staff feared retribution from **Staff #1** and **Staff #2**, and were more forthcoming after **Staff #1** and **Staff #2** left the facility.
- Some youth were unable to remember many specific incidents, potentially due to the pervasive trauma and being unable to separate the multiple violent, traumatic events.
- Records in the youth's case files were missing, including incident reports, staff and case manager progress notes for long periods of time, and monthly reports.

The focus of this investigation was narrowed to two staff persons who were involved in the majority of the referrals. **Staff #1** and **Staff #** were specifically identified by the victims and staff as responsible parties for an overwhelming majority of the alleged abuses. Other staff identified in referrals were no longer working at the facility at the time of the investigation. One sexual abuse referral involving a former youth and a former staff person was referred to the Lake County Sheriff's Department for investigation. Further Child and Family Services Division investigations with regard to abuse and neglect of youths by one or more former staff persons may occur following the conclusion of this investigation.

III. OVERVIEW OF THE INVESTIGATIVE OUTCOMES

Of the 27 youth interviewed, enough evidence was provided to investigators to determine that child abuse and neglect allegations regarding 14 of the youth could be substantiated with regard to **Staff #1** and **Staff #2**. Specific incidents and allegations are outlined in Attachments A, B and C.

Staff#1:
The intake process, as implemented by **Staff #1**, was particularly brutal. **Staff #1** was involved in the intake process for most youth admitted to the program from August 28, 2003, through October 23, 2005, and he took the lead role in the intake process within a short time of being assigned the task. Investigators estimate that **Staff #1** was involved in the intakes of more than 75 youth. Therefore, other victims of abuse from **Staff #1** potentially exist.

Staff #1 and staff under his direction physically abused youth by kicking youth doing exercises, slamming youth against the wall, roughly restraining youth on the tile floor with all of **Staff #1**'s weight on them, and making the youth exercise and drink large quantities of hot/warm water until the youth vomited.

Staff #1 psychologically abused youth through verbal insults, cursing at the youth, telling the youth that his family does not want or love him, along with the rough physical

treatment, which caused many youth to become scared and emotionally withdrawn for up to two months. Some youth exhibited symptoms of posttraumatic stress disorder when describing their intake process to the investigators.

Staff #1 also caused the youth to be exposed to an unreasonable physical and psychological risk, which is included in the state's legal definition of physical neglect. The staff's rough physical handling of the youth, requiring the youth to quickly drink large amounts of hot/warm water, and to exercise excessively placed the youth at unreasonable risk for harm, often directly causing the youth to experience symptoms of physical distress, including vomiting, hyperventilation, or difficulty breathing.

Psychological abuse of fourteen youth was substantiated against **Staff #1**. Physical abuse and physical neglect were substantiated against **Staff #1** with regard to twelve youth.

Staff #2:
As the direct supervisor of **Staff #1, Staff #2** was also directly responsible for the physical neglect, and physical and psychological abuse inflicted by **Staff #1. Staff #2** received numerous reports from other staff with regard to the child abuse and neglect of youth under the care of **Staff #1**, and though he knew or should have known these children were exposed to an unreasonable risk to their health or welfare, he failed to eliminate the risk. **Staff #2** also witnessed many of the youth intakes, and supported **Staff #1** in the implementation of the process.

In addition, the investigation revealed that **Staff #2** directly abused or neglected youth under his care during several separate incidents. **Staff #2** failed to provide or allow mental health care to youth on at least two different occasions, involving two different youth. In one case, **Staff #2** placed a youth in mechanical restraints for the evening directly after a suicide attempt, refusing the youth mental health intervention until the next day. In the second case, a youth was placed in seclusion/time out for 5 days for refusing to engage in the intake process, even though the case manager determined that the youth was suffering from severe grief after losing his dad and step dad within the past 2 months. **Staff #2** then limited the case manager's contact with the youth.

Psychological abuse of fourteen youth was substantiated against **Staff #2**. Physical abuse and physical neglect were substantiated against **Staff #2** with regard to twelve youth.

IV. FACILITY PRACTICES OF CONCERN

The investigators have serious concerns about several practices other than the youth intake procedure, all of which will require modifications in order to promote the safety of youth at the facility.

A. The "Circle" and "Ring of Fire." In each of these consequences, an uncooperative youth is placed in the center of a group of youth under the direction and supervision of staff. The group of youth is encouraged to force the uncooperative youth to do extensive exercises, and group is told to yell at the

uncooperative youth to comply, often being allowed to use information regarding the uncooperative youth's history as 'motivation' for the youth. The group of youth was allowed to curse at the youth in the center and degrade the youth for the duration of the process. The "Ring of Fire," which is reported to be the less intense of the two consequences, was carried out with Youth #8 to the point that he was crying and unable to physically walk due to the intensity of the exercises he was required to complete. The "Circle" involves exercises and running, was described by Youth #9 who was given a "circle" as a much longer and more intense process, ending with Youth #9 being "drug" around the gym after he was unable to run any further.

B. Staff curse and degrade youth at the facility without correction by the administration. Numerous staff reported that specific staff, including **Staff #1**, were allowed to curse, even when the administrator knew of the incidents. At times, the cursing was directed toward youth in a demeaning manner. In addition to cursing at the youth, staff also called the youth degrading names. **Staff #2** was involved in at least one incident where he pulled down the pants of a youth in front of other youth. The youth's underwear covered him, but the youth reported being embarrassed by this act.

C. Reports from at least two sources indicated that the **Staff #1** and **Staff #2**, along with selected other staff, resorted to using punitive measures for youth who were suffering from serious emotional issues (grief, suicide attempt, self-mutilation). In at least three instances, the youth exhibited serious mental health concerns, and due to the focus on the more militaristic approach, youth were punished, possibly exacerbating their issues. The punitive measures were carried to the point of limiting contact between the youth and his case manager.

D. From discussions with youth and staff, some staff used intimidation, brute force, threats, and misused the facility's protocol to manage the youth's behavior through an environment of fear. The following is a list of things which staff did to invoke fear into youth in the program:
   1. Physically restraining when the youth was not a physical threat to himself, others, or causing property damage. Youth were restrained when they were passively non-compliant, refusing to follow instructions, or were verbally confronting staff. During intake, youth were told that any action they took which was contrary to what they were instructed would be construed as physically aggression. This use of restraint is contrary to SVYA policy.
   2. Physical restraints used were often described as wresting holds, and police or military apprehension methods, many of which are dangerous to use with children.
   3. Several youth reported that staff encouraged the youth to hit the staff so the staff could react physically.

4. Time out and seclusion appeared to be used to punish youth, as youth were often not released once the youth worked through the issue at hand, but remained isolated for extended periods of time.
5. In some cases, mechanical restraints, including handcuffs, shackles, and soft restraints, were used past the time when the youth had calmed down, making this a punishment. For example, youth on run risk were shackled before they were taken outside, and at least one youth was shackled and handcuffed for attempting to commit suicide.

V. RECOMMENDATIONS

The investigators recommend that the program extract the practices that promote youth compliance through fear. Practices of this type place staff in the position to abuse and neglect youth without questioning, and place youth at risk for psychological and physical trauma that follow some of the youth for more than a year after discharge from the program.

The intake process, in particular, must be modified to treat the youth with human dignity and respect, and should be closely monitored in order to provide a safety measure for both the staff and youth. This process has the potential to become violent and out of control, so intakes should only be performed by staff with the ability to address difficult situations with a calm, collected approach. The facility's new intake procedure, which was witnessed by one investigator on December 16, 2005, was respectful to the youth and provided the youth with the knowledge he needed to enter the program. The improvements on the intake process were significant, and SVYA is encouraged to continue to refine the process.

Staff training is recommended in the following areas:

- De-escalation training on a regular basis, to provide staff with the ability to prevent physical situations as much as possible.
- Physical restraint training on a regular basis to allow staff to become comfortable with the approved restraint methods. Without regular training, staff will revert to other methods or to what is comfortable rather than using the approved, safer methods.
- Reporting child abuse and neglect to Centralized Intake should be trained regularly to promote the safe treatment of youth and to assure that staff recognize their mandate to report any suspected or known child abuse/neglect.
- Training on management of the treatment milieu, including how to manage the behaviors and time of the youth throughout the day in order to promote a learning environment and as prevention for more intensive behavioral issues.

Provide safeguards throughout the program for the youth that allow the youth to openly report concerns about the program. Examples of safeguards that could be added are the implementation of a youth bill of rights, allowing youth to contact parents and other

responsible people by phone without monitoring, and providing a grievance system to the youth where the youth can recognize that their concerns are heard and validated.

Records management improvements are recommended to help create a complete record of the events during a youth's stay. Improvements that are needed are to clearly document time-outs, seclusions, physical and mechanical restraints, suicide attempts, incidents and injuries, and other events that are unusual for the youth. The records in the youth's files often missed or poorly described events crucial to the youth's care and treatment. Furthermore, providing the placing workers with documentation of incidents and serious concerns about the youth would assist the worker in making the most appropriate decisions regarding the youth's case.

The final recommendation for SVYA is to re-evaluate the necessity and/or the extent of the militaristic structure implemented at the facility. SVYA staff and youth clearly demonstrated during this investigation that abusive and neglectful behaviors by staff became accepted as part of the program, primarily due to the intensity and vigor with which the militaristic approach was implemented. Such an environment is dangerous to the youth placed in the program and detrimental to the program itself. If the military structure is to remain part of the program, the program must clearly define the parameters of the militaristic approach to be utilized by the program, and this approach must never override the youth's psychological and physical needs. The continued use of military structure must be monitored to ensure the parameters are maintained, and safety measures must be in place that prohibits the military structure from superceding the human rights, safety, or treatment of the youth.

ATTACHMENT "A"

INTAKE PROCESS

The intake process seems to have been particularly brutal: the child would be placed in the seclusion cell for a period of time, anywhere between two (2) hours and nine (9) hours (however, one child was in seclusion for several days). During this time, staff, almost always **Staff #1** and two other male staff would periodically go past the cell, shout at the child and kick the door. According to the cadets, this method was extremely successful at intimidating them, many of the youths described emotions of terror and extreme fear. Nearly all children reported that when the actual intake started, **Staff #1** would throw open the door and rush into the room yelling. He would then grab the child who would be physically pulled, or semi-dragged to the space in front of the seclusion room where he was then forced to bend over a garbage can in order for his head to be shaved. Typically, this was done in a very brutal manner; one staff has reported that he refused to cut the youth's hair because he was not trained to cut hair. There were usually cuts and nicks, some bleeding occurred and odd patches of hair were left.

The child would strip, then they would be searched and sometimes forced to exercise while naked; children were sometimes left naked for extended periods of time. The de-lousing shampoo and showers were often cold and lengthy. Throughout this procedure, the male staff, typically **Staff #1** and two others, would yell at the youth, often calling the child demeaning names and casting aspersions on their family of origin, many of the youth we interviewed reported that they cried when the staff made fun of their family's and made demeaning remarks about their parents. The child was also confronted with his own behavior and those actions that had caused him to be placed in the facility.

Another issue of major concern was the practice of forcing the youth to ingest large amounts of warm water to 're-hydrate' them during the intensive exercise. This forced ingestion of excessive amounts of water in an exceedingly brief span of time, often just a few seconds, is medically dangerous because it over-hydrates the body and causes an electrolyte imbalance. It almost always induced vomiting by the child and most reported that the water was 'hot' not lukewarm. One staff at the facility objected to this practice when she discovered it and stated that she directed staff to stop.

The youths, most of whom were not physically fit, were forced to exercise excessively, doing push-ups, star jumps, sit ups and so on, generally to the point of vomiting. Some of the youths were physically abused while doing the exercises, for instance: kicked in the ribs while doing push-ups; stepped on or held down while doing push-ups; and physically punished for being either slow compliance or unable to continue exercising. Restraints, both the approved CPI holds and restraints not approved in the facilities' policy manual, were frequently utilized inappropriately during intakes, evidently to reinforce the power hierarchy.

The extent of violence utilized by staff in many of these intake procedures was so extreme that most of the youths, who underwent the severe intake procedure, seem to have dissociated during the intake experience and even now appear to evidence symptoms of relatively severe Post Traumatic Stress Disorder. Some children seem to have blocked past memories of the experiences.

One youth alleged sexual abuse by other cadets, a' game' they called t-bagging but we were not able to verify that this had occurred. Another cadet has alleged sexual abuse by a female staff member and Law Enforcement is investigating that issue. There were a significant number of former staff persons who are consistent in reporting that the management, **Staff #2** was extremely unresponsive to their concerns regarding the excessive force used to 'breakdown' youth, particularly in the intake process. Numerous cadets named **Staff #1**, who resigned shortly after the start of our investigation, as a perpetrator of both psychological and physical abuse. There were several other named staff members who have since left the organization who seem to have been very inappropriate in their methodology and abusive also. **Staff #1**, in particular seems to have instilled and promulgated a culture of terror, enforced with physical and psychological abuse which was contrary to the Cornerstone Corporations written policy. These methods were very unproductive from a treatment standpoint. **Staff #2** gave active support to **Staff #1** and refused to accept concerns from either staff or cadets. His tacit and active approval of **Staff #1**'s methods seems to have led to widespread abuses within the program. **Staff #2** stated to us that he had not received formal complaints from staff regarding concerns of abuse; however, there is evidence to the contrary.

ATTACHMENT "B"

INVESTIGATION DETAILS REGARDING STAFF #1

Youth #1:
Admission: 6/17/04. Discharge: 1/10/05

Allegations: Psychological Abuse; Physical Abuse; and Physical Neglect
Determinations: Substantiated

Explanation:
During initial intake, both **Staff #1** and another staff Sergeant, under the supervision of **Staff #1**, each laid their full body weight on Youth #1. Witnessed by staff member.
During both initial intake and a subsequent "intake" (which Youth #1 was required to re-do the intake process as a disciplinary action), Youth #1 was forced to over-exercise until he vomited. Child was given hot not tepid water to drink in order to rehydrate. Child was forced to drink the water in a hurried manner.
Child expressed fear after initial intake and states that he was "scared for two months".
Child states that whenever a new intake was done, the cadets were taken to the large classroom, the doors were closed and a movie was put in for them to watch because the intake process would bring up such bad memories,
Staff #1 who was in charge of the intake processes, allowed another staff member to place his full body weight on Youth #1 and also **Staff #1** placed his full body weight on Youth #1 during the intake process.
Staff #1, during the intake procedure, forced child to over exercise until he vomited. Reported by Youth #1 acknowledged as a common occurrence by staff.
Staff #1, who was in charge of the intake process which led to excessive fear, including symptoms of Post Traumatic Stress Disorder, such as flashbacks. This intake process inflicted psychological harm which was injurious to the child's emotional and psychological capacity to function. This is documented by the child's statement that they were required to be isolated from new intakes in order to lessen the trauma of hearing the process. Child was unable to remember other specific incidents due to the pervasive trauma and multiple violent and traumatic Youth #1 stated that as we were speaking during our telephone interview of 12/8/05, he was physically shaking - 13 months after discharge.

Youth #2:
Admission: 12/19/2003; Discharge: 11/5/2004

Allegations: Physical Neglect; Physical Abuse; Psychological Abuse
Determination: Substantiated

Explanation:
Staff #1 curtailed the child's contact with treatment staff. This was done 1-2 days after it was reported to **Staff #1** that Youth #2 might be suicidal. Also therapeutic contact was limited to 15 minutes per session. This was despite that fact that the child had already attempted suicide and

had significant mental health issues due to a history of severe trauma. Youth #2 was not allowed the normal weekly telephone visits with his family despite the recommendations of his case manager who recommended that these phone calls were necessary for Youth #2's treatment. The child was forced to drink hot water during intake and forced to over-exercise until he vomited. **Staff #1** for utilizing the usual harsh intake procedure resulting in severe trauma to the child. Youth #2 was fearful and dissociative due to the extended trauma. This was demonstrated when we conducted his interview 11 months after his discharge from the program.
Also, 11 months after discharge, Youth #2 states that there were so many incidents where he was restrained that he can't remember any specifics. He also said that he doesn't want to remember the rough handling he endured. Youth #2 stated that he was scared for the first two months he was at the facility. He expressed that he felt hopeless and was told that they took his treatment more seriously than most people so that the tougher he had it, the more he would get from it.

Youth #3:
Admission: 7/30/04; Discharge: 8/23/05

Allegations: Psychological Abuse; Physical Neglect; Physical Abuse
Determination: Substantiated

Explanation:
Staff #1 placed Youth #3 in seclusion 7/30/04 at 6:25 pm through 8/4/05 at 2:45 pm. This was due to the youth's inability to complete his intake process. It was reported to both **Staff #1** and **Staff #2** that Youth #3 had suffered the loss of both his father and stepfather due to their deaths in the previous couple of months and that the child was likely evidencing grief and shock, not oppositional behaviors.
Staff #1, during the intake procedure, pushed Youth #3 down to his knees and forced him to exercise until he had a hard time breathing. Despite no record of the child being a runaway risk, during his 5 day intake, he was shackled in order to walk to breakfast and his leg was cut on the shackles. On 8/5/04, staff members observed Youth #3 standing at attention for over three hours, in a classroom.

Youth #4:
Admission: 8/19/04. Discharge: 12/ /05

Allegations: Psychological Abuse; Physical Neglect; Physical Abuse
Determinations; Substantiated

Explanation:
During the intake, **Staff #1** grabbed Youth #4 and threw him against the wall when Youth #4 raised his arm to wipe some spittle off of his face. He was also called demeaning names: some of which were: "pussy"; "little bitch"; "spic"; and told that his family didn't care about him and his dad hated him". Youth #4 reported that the intake was so scary that he couldn't remember a lot of it, he was so scared he couldn't ask to go to the bathroom for several weeks after intake. He also said that he couldn't even write because he was so shaky. Youth #4 related that he was scared for 2 months after his intake. Also during the intake, Youth #4 was forced to exercise

without any clothes on and was unclothed for nearly 2 hours, about half of the intake. During intake, **Staff #1** gave Youth #4 water to drink but Youth #4 stated that he was so scared he could not drink it fast enough so they threw it out and gave him hot water to drink. Also, he was forced to over-exercise despite having problems with his asthma. Youth #4 also stated that he was kicked in the gut and ribs during intake but it is not clear which staff member, under the supervision of **Staff #1**, took those actions.

Youth #5:
Admission: 9/10/04; Discharge: 12/ /05

Allegations; Psychological Abuse; Physical Abuse; and Physical Neglect
Determination: Substantiated

Explanation: For the following acts or omissions, included but not limited to:
Placed in seclusion from 10:00 am until 3:30 pm prior to intake. **Staff #1** came in "raging" ; Youth #5 was grabbed and his head shaved; Child forced to do push-ups until he could not do any more; child forced to drink 160-192 ounces of warm water; bodily function was impaired to the extent that child vomited three (3) times during his intake procedure; **Staff #1** grabbed him while child was standing at attention and placed him in a 'full nelson' hold, forcing Youth #5 to the ground hitting his chest on the floor. Youth #5 states that he was standing at attention at the time this hold was initiated; Youth #5 cried for the first thirty minutes of his intake; nurse reports a very flat affect after the intake and great discouragement on the part of the youth; the rough handling during the intake placed child at an unreasonable physical and psychological risk.

Youth #6:
Admission 10/27/04; Discharge 10/27/04

Allegations: Psychological Abuse; Physical Abuse; and Physical Neglect
Determinations; Substantiated

Explanation.
Including but not limited to the followings acts and/or omissions:
Child was extremely frightened during the intake process and described **Staff #1** slamming the door to the seclusion room open, grabbing him, putting him a 'half nelson' hold and physically taking him to the garbage can to shave his head.
Child said at the time he had long bushy hair and the hair cutting process left little cuts on his head from the razor;
Child was made to over-exercise and at one point when he was noncompliant, staff member Wallin put his knee against Youth #6' neck after excessive exercise, child was forced to drink approximately 90 oz. of hot water.
Child was yelled at and called "fat ass";
Child sustained bruises on his arms where staff grabbed him and also on his knees and legs after he fell to the floor.
Nurse notes report that Youth #6 was crying and hyperventilating at 1630 hours, having a hard time doing the physical aspect of the intake Nurse wrote that staff "will take it easy on him for

remainder of intake".; at 1800 hours, nurse reported that child was "very scared", shaky and crying in her office, stated " I can't do this – get me out of here."

Youth #7:
Admission; 11/3/04; Discharge 8/19/05

Allegations: Psychological Abuse; Physical Abuse: and Physical Neglect
Determination: Substantiated

Explanation:
Including but not limited to the following acts and/or omissions:

- Child placed in seclusion for approximately 25 hours from arrival to completion of intake
- Child received " a little nick" on his head from the hair cutting.
- Child forced to drink 80 oz bottles of hot water resulting in vomiting.
- Youth #7 reports being scared for first two weeks in the program and expressed concern that staff would tackle him.
- Staff reported that **Staff #1** had Youth #7's right arm behind his back with his face up against the was. When another staff directed **Staff #1** to release the child **Staff #1** replied the "This little punk is being a pussy."
- **Staff #1** was observed to place his full body weight on the child who was lying face down on the floor with his arm twisted in a position behind his back.

Youth #8:
Admission 10/25/04

Allegations: Psychological Abuse; Physical Abuse; and Physical Neglect
Determination: Substantiated

Explanation:
Including but not limited to the following acts and/or omissions:
During Youth #8's time in seclusion prior to intake, staff repeatedly walked past the door, kicked it and yelled comments such as "You're mine"
Child reports being scared and shaken for two to three weeks after the intake which he reports "scared the shit out of me."
Because Youth #8 talked about running away due to his fear of being in the program, he was shackled when he went to the dining hall and wore shower shoes or flip-flops outside in the snow
Child was forced to over-exercise until he vomited during intake and state that he almost passed out in the shower.
While being forced to do pushups during intake, a staff member under **Staff #1's** supervision stepped on Youth #8's back, holding him to the floor while yelling at him to continue doing push ups. In February or March of 2005, as a consequence of making jokes during a graduation ceremony, **Staff #1** approved a 'Ring of Fire' consequence but **Staff #1** was not involved in it's implementation. On a Sunday, Youth #8 was placed in the center of a group of cadets at the direction of staff members [redacted] and [redacted] The cadets yelled derogatory comments and cursed at Youth #8 and he was made to over-exercise. Staff allowed the cadets to curse and yell at Youth #8 about his background resulting in Youth #8's crying. During this process Youth #8

hyperventilated and started to shake. He stated that he exercised to the point that he couldn't feel his legs.

Youth #9:
Admission 2/4/05

Allegations: Psychological Abuse
Determination: Substantiated

Explanation:
Including but not limited to the following acts and /or omissions: Child reported that during his intake, **Staff #1** and the staff member who assisted in the intake, threatened to hurt him, including a threat to beat him up.

Youth #10
Admission 2/15/05

Allegations: Physical Abuse; Physical Neglect; Psychological Abuse
Determination: Substantiated

Explanation:
Including but not limited to the following acts and/or omissions;
Child arrived at the facility at 9:00 am and was placed in seclusion until his intake began at 7:00 pm. Child was told to sit in one spot throughout the 10-hour wait prior to his intake. During the haircut, Youth #10 said he received cuts all over his head. Child was handled in a very rough manner, grabbed and taken to the hair cut garbage can, then grabbed and taken to the intake room. Child was forced to over-exercise, including "at least 50 star jumps and 100 push ups". Child was given 32 oz of water and forced to drink it in one minute resulting in Youth #10 vomiting. Nurse notes that Youth #10 vomited twice. After vomiting, Youth #10 was made to do more exercises "They smoked me again" , he was made to take a cold shower and leave the de-lousing solution on for 10 minutes. He was then given 10 seconds to get his clothes on but was unable to do so in 10 seconds so he was forced to exercise without clothes for approximately 30 minutes.

Youth #11:
Admission 5/19/05

Allegations: Psychological Abuse
Determination: Substantiated

Explanation:
Including but not limited to the following acts and/or omissions:
During intake staff yelled at child about things he and his family did to the extent that the child cried. Reports that the intake caused him to feel shocked for a couple of weeks, Stated he did not feel safe in the program and attempted to run away.

Youth #12
Admission: 5/10/05

Allegations: Physical Abuse; Physical Neglect, Psychological Abuse
Determination: Substantiated

Explanation:
Including but not limited to the following acts and/or omissions:
Youth #12 stated that he was secluded for about 45 minutes before **Staff #1** rushed into the room and grabbed him. **Staff #1** physically moved Youth #12 to the garbage can at the time-out room door and told Youth #12 to grab the can. Youth #12 picked up the can believing that he was following the instruction. **Staff #1** tackled him for not bending over the garbage can to have his hair cut. This was witnessed by staff. Youth #12 sustained a bruise on his knee from being tackled. Youth #12 was forced to over exercise by doing push-ups, star jumps, and flutter kicks. During some of the pushups, staff put their hand on his back to make it harder. He reported feeling tired and dizzy. Youth #12 was forced to drink, 'chug' warm water, first 64 oz of water then 32 oz of water. When he vomited from drinking the water so fast, he was given a very short period of time to clean up his vomit and when he did not clean it up in time, he was forced to do pushups in his vomit. During his 5-hour intake, staff yelled at him about his past issues.

Youth #13:
Admission date: 5/20/05

Allegations: Psychological Abuse; Physical Neglect; Physical Abuse
Determination: Substantiated

Explanation:
Including but not limited to the following acts and/or omissions:
Youth #13 entered the program with an injured leg, he sat in seclusion for about 2 hours before **Staff #1** entered the room, yelling at Youth #13 to get up. **Staff #1** grabbed Youth #13 by the arm before he could get up and pulled him to the garbage can where his head was quickly shaved, pulling his hair and leaving tufts of hair sticking out on his head. During the intake, **Staff #1** yelled at Youth #13, saying that his mother, who was incarcerated, had been caught with drugs and would never get out of prison, and that his dad never cared for him. Youth #13 stated that he cried during the intake, particularly when he was told that his dad was a loser and would never 'grow up' and take care of (Youth #13). Youth #13 stated that he was "petrified" for about a week after he came out of the intake, he stated that he was afraid to do anything that might cause staff to become upset with him or give him a consequence.

Youth #14
Admission: 7/12/05

Allegations: Psychological Abuse; Physical Abuse; and Physical Neglect
Determination: Substantiated

Explanation:
Including but not limited to the following acts and/or omissions:
Youth #14 was placed in seclusion for approximately 2 hours prior to his intake. He was forced to exercise excessively then forced to drink water causing him to vomit. Also, during the intake, staff yelled at him, cursed and made fun of his family. Youth #14 reports being afraid for 1 month after his intake to the extent that he sat alone in the barracks and was afraid to speak with anyone.

ATTACHMENT "C"

INVESTIGATION DETAILS REGARDING STAFF #2

Youth #1:
Admission: 6/17/04, Discharge: 1/10/05

Allegations: Psychological Abuse; Physical Abuse; and Physical Neglect
Determinations: Substantiated

Explanation:
During initial intake, both **Staff #1** and another staff Sergeant, under the supervision of **Staff #1**, each laid their full body weight on Youth #1. Witnessed by staff member.
During both initial intake and a subsequent "intake" (which Youth #1 was required to re-do the intake process as a disciplinary action), Youth #1 was forced to over-exercise until he vomited.
Child was given hot not tepid water to drink in order to rehydrate. Child was forced to drink the water in a hurried manner. During his intake, **Staff #1**placed his full weight on Youth #1, another staff member also placed his full body weight on the child during the intake process. Child expressed fear after initial intake and states that he was "scared for two months". During my interview with him in December 2005, 13 months after his discharge, Youth #1 stated that he was physically shaking due to our conversation, because it was so difficult to remember the intake.
Child states that whenever a new intake was done, the cadets were taken to the large classroom, the doors were closed and a movie was put in for them to watch because the intake process would bring up such bad memories,
Youth #1 recalled **Staff #2** telling the cadets to make things "look good" because Darrel Cash was returning to the facility. (Mr. Cash, who placed Federal kids at the facility, had reportedly told the program to make some changes or he would remove all of his placements there.) **Staff #2** also told the cadets to essentially keep their mouths shut or they would have to go through another intake process.
Staff #2 stated that he encouraged the use of warm water in order to more effectively re-hydrate the children during the intake process. One staff stated that she requested that practice be discontinued. Acknowledged by **Staff #2** that he approved the utilization of this method and the use of warm water.

Youth #2:
Admission: 12/19/2003, Discharge: 11/5/2004

Allegations: Physical Neglect; Physical Abuse; Psychological Abuse
Determination: Substantiated

Explanation:
Staff #1 curtailed the child's contact with treatment staff. This was done 1-2 days after it was reported to **Staff #1** that Youth #2 might be suicidal. Also therapeutic contact was limited to 15

minutes per session. This was despite that fact that the child had already attempted suicide and had significant mental health issues due to a history of severe trauma.
Staff #1 forced the child to drink hot water during intake and forced Youth #2 to over-exercise until he vomited.
Staff #2 for curtailing child's contact with treatment staff, 2-3 days after it was reported to both himself and **Staff #1** that Youth #2 might be suicidal. Also, child was limited to 15 minutes per therapeutic session and was not allowed to initiate contact with his case manager. This was despite the fact that Youth #2 had already attempted suicide and had a history of severe trauma in conjunction with significant mental health needs. Also the child was not allowed the normal weekly telephone visits with his family despite the recommendations of his case manager. The harsh intake procedure resulted in Youth #2 being fearful and dissociating due to the extended trauma. This was demonstrated when we conducted his interview 11 months after his discharge from the program. Also, child was not allowed telephone visits with his mother for a period of months despite the recommendation of his case manager that these visits were necessary.
Staff #2 for maintaining a child in his program who was clearly in need of more therapeutic and mental health oriented treatment. He was not provided with the necessary therapy to address his needs. Also, 11 months after discharge, Youth #2 states that there were so many incidents where he was restrained that he can't remember and also he says that he doesn't want to remember the rough handling he endured. Youth #2 stated that he was scared for the first two months he was at the facility. He expressed that he felt hopeless and was told that they took his treatment more seriously than most people so that the tougher he had it, the more he would " get from it ".

Youth #3:
Admission: 7/30/04, Discharge, 8/23/05

Allegations: Psychological Abuse; Physical Neglect; Physical Abuse
Determination: Substantiated

Explanation:
Staff #1 placed Youth #3 in seclusion 7/30/04 at 6:25 pm through 8/4/05 at 2:45 pm. This was due to the youth's inability to complete his intake process. It was reported to both **Staff #1** and **Staff #2** that Youth #3 had suffered the loss of both his father and stepfather due to their deaths in the previous couple of months and that the child was likely evidencing symptoms of grief.
Staff #2 approved all decisions to use the seclusion room. **Staff #1** placed Youth #3 in seclusion 7/30/04 at 6:25 pm through 8/4/05 at 2:45 pm. This was due to the youth's inability to complete his intake process. It was reported to both **Staff #1** and **Staff #2** that Youth #3 had suffered the loss of both his father and stepfather due to their deaths in the previous couple of months and that the child was likely evidencing grief and shock, not oppositional behaviors. On 8/5/04, staff members observed Youth #3 standing at attention for over three hours, in a classroom.
Staff #1, during the intake procedure, pushed Youth #3 down to his knees and forced him to exercise until he had a hard time breathing. Despite no record of the child being a runaway risk, during his 5-day intake, he was shackled in order to walk to breakfast and his leg was cut on the shackles

Youth #4:
Admission: 8/19/04. Discharge: 12/ /05

Allegations: Psychological Abuse; Physical Neglect; Physical Abuse
Determinations: Substantiated

Explanation:
During the intake, **Staff #1** grabbed Youth #4 and threw him against the wall when Youth #4 raised his arm to wipe some spittle off of his face. He was also called demeaning names: some of which were: "pussy;" "little bitch;" "spic;" and told that his family didn't care about him and his dad hated him." Youth #4 reported that the intake was so scary that he couldn't remember a lot of it; he was so scared he couldn't ask to go to the bathroom for several weeks after intake. He also said that he couldn't even write because he was so shaky. Youth #4 related that he was scared for 2 months after his intake. Also during the intake, Youth #4 was forced to exercise without any clothes on and was unclothed for nearly 2 hours, about half of the intake.
During intake, **Staff #1** gave Youth #4 water to drink but Youth #4 stated that he was so scared he could not drink it fast enough so they threw it out and gave him hot water to drink. Also, he was forced to over-exercise despite having problems with his asthma. Youth #4 also stated that he was kicked in the gut and ribs during intake but it is not clear which staff member, under the supervision of **Staff #1**, took those actions.
Sometime in July 2005, **Staff #2** told Youth #4 to stand in front of the group and put his hands out from his sides and face everybody. **Staff #2** then pulled down Youth #4's outer pants and everybody laughed. Youth #4 was needlessly humiliated.

Youth #5:
Admission: 9/10/04, Discharge: 12/ /05

Allegations; Psychological Abuse; Physical Abuse; and Physical Neglect
Determination: Substantiated

Explanation: For the following acts or omissions, included but not limited to:
Placed in seclusion from 10:00 am until 3:30 pm prior to intake; **Staff #1** came in "raging"; Youth #5 was grabbed and his head shaved; Child forced to do push-ups until he could not do any more; child forced to drink 160-192 ounces of warm water; bodily function was impaired to the extent that child vomited three (3) times during his intake procedure; **Staff #1** grabbed him while child was standing at attention and placed him in a 'full nelson' hold, forcing Youth #5 to the ground hitting his chest on the floor. Youth #5 states that he was standing at attention at the time this hold was initiated; Youth #5 cried for the first thirty minutes of his intake; nurse reports a very flat affect after the intake and great discouragement on the part of the youth; the rough handling during the intake placed child at an unreasonable physical and psychological risk.

Youth #6:
Admission 10/27/04; Discharge 10/27/04

Allegations: Psychological Abuse; Physical Abuse; and Physical Neglect
Determinations: Substantiated

Explanation.
Including but not limited to the followings acts and/or omissions:
Child was extremely frightened during the intake process and described **Staff #1** slamming the door to the seclusion room open, grabbing him, putting him a 'half nelson' hold and physically taking him to the garbage can to shave his head.
Child said at the time he had long bushy hair and the hair cutting process left little cuts on his head from the razor;
Child was made to over-exercise and at one point when he was noncompliant, staff member Wallin put his knee against Youth #6' neck after excessive exercise, child was forced to drink approximately 90 oz. of hot water.
Child was yelled at and called "fat ass";
Child sustained bruises on his arms where staff grabbed him and also on his knees and legs after he fell to the floor.
Nurse notes report that Youth #6 was crying and hyperventilating at 1630 hours, having a hard time doing the physical aspect of the intake Nurse wrote that staff "will take it easy on him for remainder of intake." At 1800 hours, nurse reported that child was "very scared", shaky and crying in her office, stated " I can't do this – get me out of here"

<u>**Youth #7:**</u>
Admission; 11/3/04; Discharge 8/19/05

Allegations: Psychological Abuse; Physical Abuse: and Physical Neglect
Determination: Substantiated

Explanation:
Including but not limited to the following acts and/or omissions:
- Child placed in seclusion for approximately 25 hours from arrival to completion of intake
- Child received " a little nick" on his head from the hair cutting
- Child forced to drink 80 oz bottles of hot water resulting in vomiting
- Youth #7 reports being scared for first two weeks in the program and expressed concern that staff would tackle him
- Staff reported that **Staff #1** had Youth #7's right arm behind his back with his face up against the wall. When another staff directed **Staff #1** to release the child **Staff #1** replied the "This little punk is being a pussy."
- **Staff #1** was observed to place his full body weight on the child who was lying face down on the floor with his arm twisted in a position behind his back

<u>**Youth #8:**</u>
Admission 10/25/04

Allegations: Psychological Abuse; Physical Abuse; and Physical Neglect
Determination: Substantiated

Explanation:
Including but not limited to the following acts and/or omissions:
During Youth #8's time in seclusion prior to intake, staff repeatedly walked past the door, kicked it and yelled comments such as "You're mine."
Child reports being scared and shaken for two to three weeks after the intake that he reports "scared the shit out of me."
Because Youth #8 talked about running away due to his fear of being in the program, he was shackled when he went to the dining hall and wore shower shoes or flip-flops outside in the snow
Child was forced to over-exercise until he vomited during intake and state that he almost passed out in the shower.
While being forced to do pushups during intake, a staff member stepped on Youth #8's back, holding him to the floor while yelling at him to continue doing push ups. In February or March of 2005, as a consequence of making jokes during a graduation ceremony, **Staff #1** approved a 'Ring of Fire' consequence but **Staff #1** was not involved in it's implementation. On a Sunday, Youth #8 was placed in the center of a group of cadets at the direction of staff members [redacted] [redacted]. The cadets yelled derogatory comments and cursed at Youth #8 and he was made to over-exercise. Staff allowed the cadets to curse and yell at Youth #8 about his background resulting in Youth #8's crying. During this process Youth #8 hyperventilated and started to shake. He stated that he exercised to the point that he couldn't feel his legs.

Youth #9:
Admission 2/4/05

Allegations: Psychological Abuse
Determination: Substantiated

Explanation:
Including but not limited to the following acts and /or omissions: Child reported that during his intake, **Staff #1** and the staff member who assisted in the intake, threatened to hurt him, including a threat to beat him up.

Youth #10
Admission 2/15/05

Allegations: Physical Abuse; Physical Neglect; Psychological Abuse
Determination: Substantiated

Explanation:
Including but not limited to the following acts and/or omissions;
Child arrived at the facility at 9:00 am and was placed in seclusion until his intake began at 7:00 pm. Child was told to sit in one spot throughout the 10-hour wait prior to his intake. During the haircut, Youth #10 said he received cuts all over his head. Child was handled in a very rough manner, grabbed and taken to the hair cut garbage can, then grabbed and taken to the intake room. Child was forced to over-exercise, including "at least 50 star jumps and 100 push ups". Child was given 32 oz of water and forced to drink it in one minute resulting in Youth #10 vomiting. Nurse notes that Youth #10 vomited twice. After vomiting, Youth #10 was made to

do more exercises "They smoked me again", he was made to take a cold shower and leave the de-lousing solution on for 10 minutes. He was then given 10 seconds to get his clothes on but was unable to do so in 10 seconds so he was forced to exercise without clothes for approximately 30 minutes.

Youth #11:
Admission 5/19/05

Allegations: Psychological Abuse
Determination: Substantiated

Explanation:
Including but not limited to the following acts and/or omissions:
During intake staff yelled at child about things which he and his family did, to the extent that the child cried. Reports that the intake caused him to feel shocked for a couple of weeks. Stated he did not feel safe in the program and attempted to run away.

Youth #12:
Admission: 5/10/05

Allegations: Physical Abuse; Physical Neglect; Psychological Abuse
Determination: Substantiated

Explanation:
Including but not limited to the following acts and/or omissions:
Youth #12 stated that he was secluded for about 45 minutes before **Staff #1** rushed into the room and grabbed him. **Staff #1** physically moved Youth #12 to the garbage can at the time-out room door and told Youth #12 to grab the can. Youth #12 picked up the can believing that he was following the instruction. **Staff #1** tackled him for not bending over the garbage can to have his hair cut. Staff witnessed this. Youth #12 sustained a bruise on his knee from being tackled. Youth #12 was forced to over exercise by doing push-ups, star jumps, and flutter kicks. During some of the pushups, staff put their hand on his back to make it harder. He reported feeling tired and dizzy. Youth #12 was forced to drink, 'chug' warm water, first 64 oz of water then 32 oz of water. When he vomited from drinking the water so fast, he was given a very short period of time to clean up his vomit and when he did not clean it up in time, he was forced to do pushups in his vomit. During his 5-hour intake, staff yelled at him about his past issues.

Youth #13:
Admission date: 5/20/05

Allegations: Psychological Abuse; Physical Neglect; Psychological Abuse
Determination: Substantiated

Explanation:
Including but not limited to the following acts and/or omissions:

Youth #13 entered the program with an injured leg; he sat in seclusion for about 2 hours before **Staff #1** entered the room, yelling at Youth #13 to get up. **Staff #1** grabbed Youth #13 by the arm before he could get up and pulled him to the garbage can where his head was quickly shaved, pulling his hair and leaving tufts of hair sticking out on his head. During the intake, **Staff #1** yelled at Youth #13, saying that his mother, who was incarcerated, had been caught with drugs and would never get out of prison, and that his dad never cared for him. Youth #13 stated that he cried during the intake, particularly when he was told that his dad was a loser and would never 'grow up' and take care of (Youth #13). Youth #13 stated that he was "petrified" for about a week after he came out of the intake, he stated that he was afraid to do anything that might cause staff to become upset with him or give him a consequence.

Youth #14
Admission: **7/12/05**

Allegations: Psychological Abuse; Physical Abuse; and Physical Neglect
Determination: Substantiated

Explanation:
Including but not limited to the following acts and/or omissions:
Youth #14 was placed in seclusion for approximately 2 hours prior to his intake. He was forced to exercise excessively then forced to drink water causing him to vomit. Also, during the intake, staff yelled at him, cursed and made fun of his family. Youth #14 reports being afraid for 1 month after his intake to the extent that he sat alone in the barracks and was afraid to speak with anyone.