

Learning From Tragedy: Restraint Fatalities In Child Welfare, Mental Health And Juvenile Corrections Facilities

by *Michael Nunno, D.S.W.*
Martha Holden, M.S.

PROBLEM UNDER STUDY

The 1998 *Hartford Courrant* series documented 142 child and adult fatalities over a 10-year period where physical and mechanical restraints, psychotropic medication, isolation and/or seclusion contributed to the cause of death. Subsequent federal and state legislation limited or banned the use of physical and mechanical interventions with children and other vulnerable populations. These legislative and regulatory changes had little but newspaper accounts for guidance. This guidance has led to naïve and one-dimensional solutions.

OBJECTIVES

The objectives of this study are to determine the frequency and circumstances of child fatalities due to physical holds, restraints or interventions in 24-hour child treatment facilities.

METHOD

Since its inception, the Fatality Study has documented 44 incidents since 1993 using a combination of Internet searches, surveys to states, access through civil litigation, and state and agency fatality reviews.

RESULTS

44 fatalities were documented. Ages ranged from 6 to 17 years (mean=14 years). Fatalities were overwhelmingly male (n=31). Asphyxia (positional/ compression/mechanical) was the leading cause of death (n=28). Cardiac arrhythmia or cardiac arrest occurred in 9 cases, while the remaining causes were listed as internal bleeding (N=1), hypothermia (N=1) and unspecified or unknown (N=5). While psychotropic medications were present in 8 fatalities, the psychotropic medication history was unknown in the vast majority of cases. Mechanical restraints were used in 8 fatalities, while 27 fatalities were a result of some form of physical holding. Nine cases were unknown to us at the time of this writing.

Some facilities included a combination of physical, mechanical, chemical restraints and/or isolation. In 11 of the 44 cases there was one staff involved. In 10 of the fatalities 2 staff were involved; in 5 cases, 3 staff were involved; in 5 cases, 4 staff were involved; in 1 case, 6 staff were involved; and in the remaining, the number of staff involved was unknown.

What was the stated Rationale for Restraints/Seclusions (N=27)

- Refused to comply while in Time Out room (7)
- Escorting to or from somewhere (2)
- Fighting with peers (2)
- Aggressive with staff (2)
- Noncompliant behavior (10) such as refused to give up a picture, a pen or to put on shoes; wanted to leave group therapy, classroom, gym; running around

Immediate Causes—the last link in the chain of events, undesirable acts or conditions, such as violent behavior, failure to make plans or give instructions, no supervision.

- Agitation prior to or during restraint
- Restraints were conducted without monitoring
- Weight, pressure or positional pressure on child's upper torso, neck, chest, back
- Restricted breathing
- Signs of distress were ignored (e.g., "I can't breathe" (13), vomited (6), turned blue (4))
- Combination of medication, agitation, restraint, medical condition of child
- Dangerous restraint techniques
- Failure to seek/start emergency medical procedures
- Counter-aggression from staff

Basic Causes—how the employee's role or the practice is performed, personal factors of the persons doing the job, staff supervision, compliance expectations.

- Unrestricted use of restraints and dependence on restraints for other than safety, usually to enforce compliance to program rules or staff requests
- High-risk and dangerous practices condoned by facility
- Insufficient review, monitoring of restraints
- No awareness of/consideration of risk factors surrounding use of restraints
- Inadequate or no training of staff in crisis management
- Inadequate or no supervision, no reflective practice
- Professional courtesy translated to no questioning of others' interventions
- No individual crisis management plans or strategies
- Inappropriate placement/inadequate resources

Root Causes—what ultimately caused or contributed to the incident, systemic and organizational culture factors.

- Inadequate or non-existent treatment philosophy
- Inadequate or non-existent programming
- Children's rights ignored
- Non-compliance to regulations and standards
- Inadequate staffing resources (e.g., staff/client ratios, training/education)
- Policies/procedures inadequate/out-dated
- No internal monitoring system
- Organizational culture supports restraint as a strategy for program compliance, therapy, and/or punishment

CONCLUSIONS

Physical and mechanical restraints are prescribed by many facilities as a measure to ensure that children do not harm themselves and other children. A knowledge base must be built to ensure that an intervention to maintain a safe environment is not riskier than the anticipated harm. The multiple causes of restraint fatalities in child care facilities resist one-dimension solutions. Using physical holds for safety reasons in residential child treatment facilities demands the vigilance of the facility's leaderships, its supervisors, clinical and training staffs. Monitoring all critical incidents is essential. Monitoring should address the organizational components of any critical events, and address prevention of future events, and risk reduction.

Circumstances and common dynamics surrounding fatalities suggest no one clear reason for fatalities, but indicate a combination of factors. Some agencies/states have reacted to fatality reports by banning certain practices or instituting regulations/rules based on one or two reported incidents. These solutions ignore the complex multi-causal factors discovered in our study.

STUDY LIMITS

There was difficulty obtaining child fatality information from state agency information management systems. All but three states reported they did not routinely review child fatalities in residential care. Facilities and individuals involved in the event are often reluctant to assess the events and the contributing circumstances. Criminal and civil actions are often a part of the aftermath of these tragedies, and most often cited as the reason for this reluctance. This points to the need for ongoing fatality reviews by an independent agency to assess the immediate supervision, clinical oversight, training and staffing other related circumstances that contributed to these events.

AUTHORS

Michael Nunno and Martha Holden are senior extension associates with the Family Life Development Center at the College of Human Ecology, Cornell University. Dr. Nunno is the Principal Investigator, and Ms. Holden is the Project Director of the Residential Child Care Project. The Project assists governmental jurisdictions to develop institutional child abuse prevention and investigations systems, and governmental and non-governmental residential treatment and youth corrections facilities develop crisis prevention and management systems. The Project's assessment and implementation strategies reduce the levels of physical aggression between staff and children, and children and children in residential care and treatment.

Michael Nunno, D.S.W.
Senior Extension Associate
Family Life Development Center
College of Human Ecology, Cornell University
Ithaca, NY 14853
607 254 5127
man2@cornell.edu

Martha Holden, M.S.
Senior Extension Associate
Family Life Development Center
College of Human Ecology, Cornell University
Ithaca, NY 14853
607 254 5337
mjh19@cornell.edu