RESIDENTIAL CHILD CARE PROJECT, CORNELL UNIVERSITY

QuickTRIP (Translating Research Into Practice) February 2022

What We Know About Children Who Have Died from Restraint in Out-of-Home Care

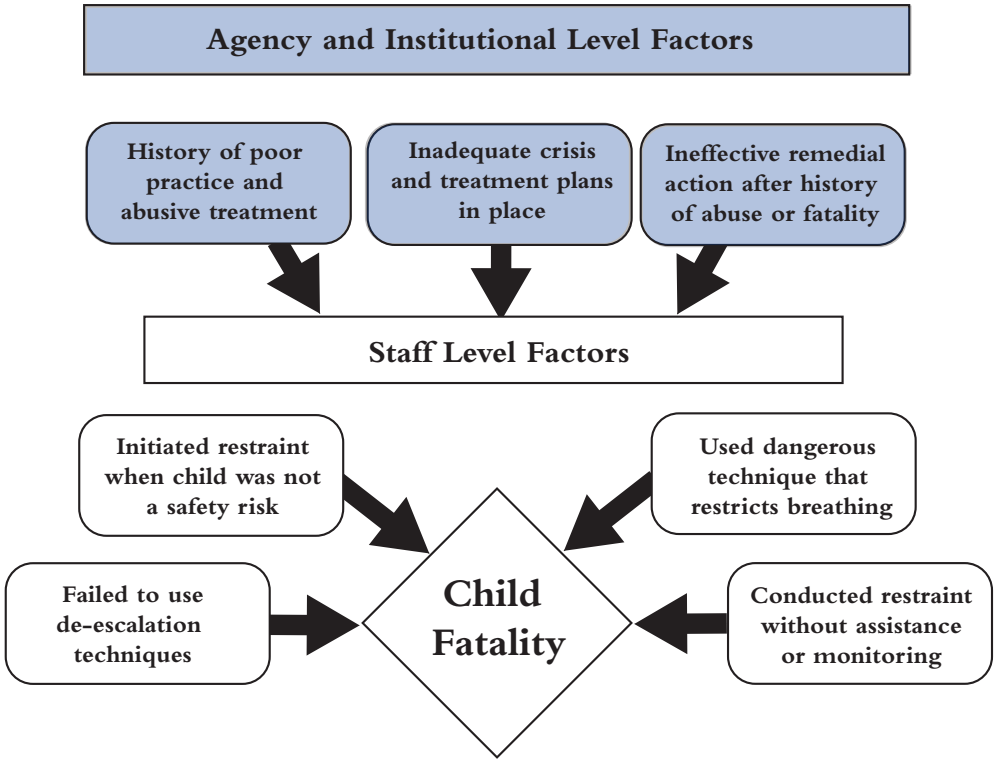
Researchers from the RCCP identified and examined 79 child fatalities that occurred in out-of-home care in the U.S. due to restraint practices. Cases span a 26-year period. The research provides a picture of how the fatalities occurred and the consequences for staff and agencies where the deaths took place. Of the 75 fatalities in which the type of restraint was indicated, 80% involved physical restraints and 16% involved mechanical restraints (e.g., carpet, boards). In 60% of the 79 fatalities, death occurred due to asphyxia.*

Plymouth, age 16†

A shirt Plymouth loved was missing from her closet. Angered, she ran to her friend to accuse her of taking it. She was stopped and escorted back to her room by a staff member. Agitated, she went into her closet to prove to him it was gone and she retrieved a small object. Staff demanded to know what was in her hand; she refused to comply. A supervisor, hearing the disturbance, shouted "settle her down in there it's time for dinner." Responding, the caregiver initiated a single-person restraint in the closet, lost her balance, and fell on Plymouth who landed face-up. Staff remained on Plymouth's torso to maintain control until she was non-responsive. Plymouth died from asphyxiation. Her death was the 4th restraint-related fatality within the organization over the past 8 years. Days prior to Plymouth's death, the state's regulatory agency placed the center on probation because of "excessive" restraints, the frequent use of medication for control, and the lack of individualized treatment and crisis plans. Two years prior, leadership and staff were cited for abuse when they "encouraged" the girls to wrestle with one another for food, snacks, and prizes.

Confluence of Factors Contributing to Plymouth's Death

Deaths occurred due to many interacting factors. Note that all of these factors are within an agency's power to resolve.



*Nunno, M. A., McCabe, L. A., Izzo, C. V., Smith, E. G., Sellers, D. E., & Holden, M. J. (2021). A 26-year study of restraint fatalities among children and adolescents in the United States: A failure of organizational structures and processes. *Child & Youth Care Forum*. *DOI*: 10.1007/s10566-021-09646-w

†This composite narrative represents features of restraint fatality incidents reviewed for this study. A composite is reported in order to efficiently illustrate the confluence of factors typically seen, while also protecting the identity of children and their caregivers.

Practice Considerations

Based on the results of Nunno et al (2021), the authors, who are TCI Instructors and/or CARE Consultants, suggest that agency staff consider the following questions to assess and increase safety, transparency, and monitoring in their organization.

For Leaders

- How does our organizational culture, including our policies and practices, influence the use of restraints?
- Does our agency adhere to the practice principles addressed in the article? (Click here to access article.)
- Does our organization's culture support "safety attentiveness" or "safety deafness"?
- Does our resource allocation adequately provide for necessary restraint prevention conditions such as adequate training, appropriate staffing levels, and safety mechanisms?
- How do we communicate the use of restraints to families and youth at intake and during residency?
- Do events involving the use of high-risk intervention receive timely and rigorous administrative examination?
- Does the program provide direct care staff with a menu of options to choose from in responding to violent behavior?

For Trainers

- Am I training Therapeutic Crisis Intervention (TCI) with fidelity and do I advocate for fidelity in overall agency implementation?
- How effectively do I communicate staffs' training needs to their supervisors?
- Do I confirm, through training and feedback, that staff members know about the risk of obstructing a child's breathing during a restraint?
- Do I reinforce the expectation and facilitate practice on how to respond to a safety violation during a restraint?
- Do I train and practice how to respond to medical emergencies that may occur during a restraint?

For Supervisors

- What support and expectations do I communicate about the use of restraints, especially when staff witness safety violations?
- How effectively do I communicate my staff's training needs to TCI trainers?
- Do my unit's culture and climate encourage learning and self-reflection?

For Supervisors, cont.

- Do I expect competence in de-escalation skills and restraint techniques from my staff?
- What do I do to ensure the ongoing skill development of my staff?
- Do I talk with my staff before training to communicate my expectations for their participation and meet with them after to set goals for continued knowledge and skill advancement?

For Clinical and Medical Staff

- Do we use Individual Crisis Support Plans (ICSPs) effectively within the agency or school? How do we know?
- Is restraint use indicated prescriptively on ICSPs?
- Do our medical and psychological assessments clearly indicate that restraints may trigger trauma-induced responses and in some cases may be contraindicated?
- Do we have stringent safety and emergency mechanisms in place to minimize risk in the event a restraint causes injury?
- Do we monitor children during restraints for signs of distress?

For Direct Care Staff

- How does my unit's culture and climate influence our restraint use?
- Am I competent in my skills to reduce the risks of a restraint injury or fatal outcome?
- Can I de-escalate crisis situations?
- Do I have access to skill development outside of the training room?
- Do I monitor children during restraints for signs of distress?
- Do I know that I can and should intervene when I witness a restraint safety violation?

Facts About the Child Fatalities

95% triggered a regulatory, licensing, or abuse investigation

80% involved a physical restraint

60% were caused by asphyxia, due to various factors such as breathing obstructions, improper positioning

31% resulted in civil action

30% resulted in criminal action

16% involved mechanical restraints (straps, boards, other rigid devices, handcuffs, or children wrapped in a carpet, blanket, or mattress)

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QuickTRIPs are translations of RCCP research for practitioners.