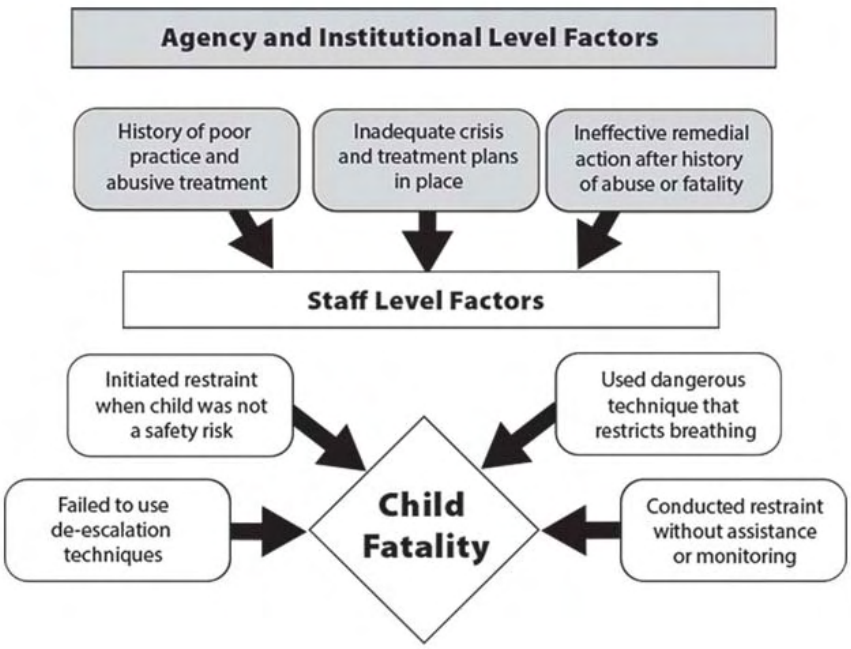
# Restraint factors attributed to a confluence of medical, psychological, and organizational factors




Examination of 79 U.S. child fatalities that occurred due to restraint practices in out-of-home care over a 26-year period (1993-2018) provides a picture of the children who died and how the fatalities occurred. The composite case presented below represents features of restraint fatality incidents reviewed for this study. A composite is reported in order to efficiently illustrate the confluence of interacting factors typically seen, while also protecting the identity of children and their caregivers. Note that any of these factors are within an agency's power to resolve.

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.

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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.* https://doi.org/10.1007/s10566-021-09646-w

 