

# **DISABILITY LAW CENTER INVESTIGATION REPORT**

## **CHAMBERLAIN INTERNATIONAL SCHOOL – MIDDLEBORO, MA**

### **I. Introduction**

The Disability Law Center (DLC) is a private, non-profit organization which is designated to provide protection and advocacy (“P and A”) services to individuals with mental illness, pursuant to a congressional mandate under the Protection and Advocacy for Individuals with Mental Illness Act (PAIMI), 42 U.S.C. §§ 10801 et seq.; protection and advocacy services to individuals with developmental disabilities, pursuant to the Protection and Advocacy for Individuals with Developmental Disabilities Act (PAIDD), 42 U.S.C. §§ 15043 et seq.; protection and advocacy services for individuals with disabilities who do not qualify for services under either the PAIMI or the PAIDD Programs, pursuant to the Protection and Advocacy of Individual Rights Program of the Rehabilitation Act of 1973, (PAIR), 29 U.S.C. §§ 794e et seq.; and for individuals with traumatic brain injury, pursuant to the Protection and Advocacy for Individuals with Traumatic Brain Injury (PATBI), 42 U.S.C. § 300d-53. Pursuant to these federal mandates, DLC is authorized to investigate incidents of alleged abuse and neglect of people with disabilities throughout the Commonwealth of Massachusetts.

In May 2015, DLC received a complaint from a parent of a student, as well as a videotaped complaint by the student, regarding the treatment of students at the Chamberlain International School (CIS, Chamberlain or the School), located in Middleboro, Massachusetts. Soon thereafter DLC also received a complaint from a former student alleging additional concerns at the school. After interviewing these individuals and reviewing records that were provided, DLC contacted CIS and informed them that DLC had received a complaint to the system and requested to visit the School and speak with staff and students during this visit to investigate the serious allegations that had been made. DLC explained its legal authority to visit the campus to interview staff and students pursuant to these Protection and Advocacy Laws. DLC’s letter to CIS, dated May 11, 2015, sought to visit the school on Friday, May 15. There was a series of communications between DLC and CIS about whether CIS would allow DLC to visit the school to commence its investigation, but DLC’s efforts to obtain access to the campus, staff and students through direct negotiation were ultimately unsuccessful. DLC filed a lawsuit in federal district court, seeking a preliminary injunction ordering the school to provide DLC access to conduct its investigation. The suit alleged that the refusal of CIS to afford DLC access to conduct interviews of students and staff at the school

improperly prevented DLC from being able to fulfill its federal mandate to investigate allegations of abuse and neglect of people with disabilities.

## **II. BACKGROUND**

After the suit was filed, the parties entered an initial agreement whereby CIS would allow DLC to begin its investigation with a visit to the campus on June 12, 2015. On that date, school staff gave DLC a tour of the campus of the school, but the parties could not reach agreement concerning DLC's request to interview students enrolled in the school. After much discussion and debate about whether DLC could conduct student interviews, CIS then agreed to allow student interviews to begin on July 13, 2015. After the first day of interviews, there was further discussion and debate concerning the timing and manner of additional student interviews. Ultimately a second and third day of student interviews occurred on July 27 and July 28, 2015. In total, DLC conducted interviews of 43 students. DLC also conducted approximately a dozen interviews of CIS staff on July 20, 21 and 23, 2015. At the same time, in response to DLC's request, CIS provided contact information for existing students at the school. On July 31, 2015, using the contact information provided by CIS, DLC sent a letter to each of the families of students explaining the nature and scope of the investigation and asking families whether they had any information, positive or negative, that they wished to share with DLC. In response to that letter, many families did contact DLC and shared information about their experiences with the school. Some families expressed real satisfaction with the school, while others were quite critical of the school. Over the course of its investigation, DLC spoke with 26 parents of current or former students, as well as a half dozen former students.

Throughout the fall, there was much discussion and debate concerning DLC's access to student records. In late September, DLC made the requisite procedural finding under the federal PAIMI regulations, which established the basis for DLC to seek records of certain students at CIS. A process was ultimately agreed upon by the parties and in December, DLC sought the records for twenty students, which CIS did provide.

The School had sought an opportunity to meet with DLC staff in order for CIS to be able to explain, rebut, or put into proper context any concerns that DLC may have as a result of their investigation. In advance of that meeting, DLC provided the school with a list of issues of concern and provided the names of student exemplars. On June 21, 2016, CIS staff and their counsel came to DLC and had an opportunity to respond to the concerns that had been identified to date. Counsel for CIS also asked that some of the initial allegations received by DLC that had been cited in the original federal court complaint that had not been substantiated be corrected in the pending federal court complaint. DLC agreed to amend its complaint to reflect the fact that the substance of some of those initial allegations had not been substantiated and that DLC was

continuing to investigate other allegations concerning the school. A second discussion of DLC's identified concerns occurred on August 4, 2016 with Chamberlain and its counsel.

### **III. LEGAL AUTHORITY**

Protection and Advocacy systems, such as DLC, have express authority under the Protection and Advocacy laws to gain broad access to records, facilities and residents to ensure that vulnerable individuals with disabilities are afforded access to protection and advocacy services. DLC, as the designated Protection and Advocacy System for Massachusetts, is authorized under the PAIMI statute to "investigate incidents of abuse and neglect of individuals with mental illness if the incidents are reported to the system or if there is probable cause to believe that the incidents occurred." 42 USC § 10805(a)(1)(A).<sup>1</sup> As noted above, this investigation was commenced based upon a "complaint to the system."

The PAIMI regulations define the terms "abuse" and "neglect" as follows:

Abuse means any act or failure to act by an employee of a facility rendering care or treatment which was performed, or which was failed to be performed, knowingly, recklessly, or intentionally, and which caused, or may have caused, injury or death to an individual with mental illness, and includes but is not limited to acts such as: rape or sexual assault; striking; the use of excessive force when placing an individual with mental illness in bodily restraints; the use of bodily or chemical restraints which is not in compliance with Federal and State laws and regulations; verbal, nonverbal, mental and emotional harassment or any other practice which is likely to cause immediate physical or psychological harm or result in long term harm if such practices continue.

42 C.F.R. § 51.2.

Neglect means a negligent act or omission by an individual responsible for providing services in a facility rendering care or treatment which caused or may have caused injury or death to an individual with mental illness or which placed an individual with mental illness at risk of injury or death, and includes but is not limited to acts or omissions such as failure to: establish or carry out an appropriate individual program or treatment plan (including a discharge plan);

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<sup>1</sup> As noted above, this investigation was initiated under PAIMI, PAIDD, PATBI and PAIR. Although the substantive provisions of these laws are substantially the same, some of the procedural aspects concerning investigations (e.g., the particular methods and requirements for obtaining parental or guardian consent) vary among the various P and A programs. Counsel for CIS argued that PAIMI was the most applicable statute. Without conceding the correctness of that position, but in order to avoid further delay and move the investigation forward expeditiously, DLC agreed to follow the PAIMI requirements.

provide adequate nutrition, clothing, or health care; and the failure to provide a safe environment which also includes failure to maintain adequate number of appropriately trained staff.

42 C.F.R. § 51.2.

#### **IV. Factual Findings**

##### **A. Serious Self-Injurious Behavior**

DLC originally received complaints in May of 2015 that the Chamberlain School failed to provide students with medical attention after a suicide attempt. While DLC did not find evidence to validate this allegation, DLC did find evidence to support a finding of neglect on Chamberlain's part to prevent and properly respond to student suicide attempts or other acts of serious self-injurious behavior. Under the federal regulations cited above (page 3), neglect includes acts or failures to act by a caretaker that put students with mental illness at risk of injury or death. See 42 C.F.R. 51.2.

Chamberlain states on its website that it provides "comprehensive and intensive therapeutic programming." DLC acknowledges that many of the students at Chamberlain have complicated needs and profiles. However, that is precisely the reason why many of them are attending Chamberlain. DLC did speak to some parents who felt their child did well at Chamberlain, and DLC reviewed the records of one student who appeared to do well at the school. This student had previously been in a more restrictive setting, and seemed to attend Chamberlain without any notable incidents. Nevertheless, DLC found that Chamberlain had actual notice that these students in the examples below had histories of self-injurious behavior, suicidal ideation and in some cases, past suicide attempts. Further, with many of these students, they had expressed suicidal ideation to Chamberlain staff before their attempt. As described in the examples below, some students used the very same means for attempts multiple times.

There have been multiple suicide attempts at Chamberlain in the past year and a half. Many students told DLC they were concerned about students jumping out of windows. According to the school, their "close watch" policy is a "heightened level of supervision in response to a student expressing feelings of self-harm." This plan is for students who do not meet the level of need for the "at risk" of suicide policy, but still need heightened supervision due to self-injurious threats or actions, symptoms of depression or even health issues. If a student is put on "close watch," protocols include having staff keep the student in sight, conducting increased bed checks at night, and keeping bathroom breaks short and having staff monitor outside the door. This is different from Chamberlain's "at risk" plan which is a higher level of supervision and concern for a student who is at risk of suicide. Under this plan, the protocols include the following: students receive a heightened level of care including supervision by direct care staff at all times, being searched for dangerous materials, not receiving access to

cleaning materials, and not allowing the student to lock or fully close the bathroom door. Chamberlain also has an internal investigation protocol that states the school “conducts internal investigations of any serious incident involving health and safety of students.”

#### Student 1

One student jumped out of a second story dorm bathroom window after asking staff to take a shower. This student had a history of previous suicide attempts and suicidal ideations, including one where the student received treatment after jumping off buildings into the snow. This student had also previously tried to jump off the second floor of a residence at Chamberlain, but was prevented by staff. In the incident in question, the student sustained serious injuries after the jump out of the window and required treatment at a Boston hospital. The student never returned to Chamberlain following this incident.

Chamberlain informed DLC that they do not characterize this incident as a suicide attempt because the student jumped into a pile of snow and reportedly told staff he or she<sup>2</sup> thought the snow was deeper. While DLC understands that position, a review of all the circumstances, both before and after the jumping incident, causes DLC to conclude that in fact this student’s actions were an attempt to cause serious self-harm. Review of the student’s file revealed that this student had a history of suicidal ideation before attending Chamberlain. In addition, other events that happened at Chamberlain leading up to this incident, and the treatment the student received at other facilities after this jumping incident, makes DLC conclude that the view that this incident was not an attempt at serious self-injury is not correct.

Based upon review of the student’s records, DLC found that the student had a past history of several suicide attempts, including at Chamberlain prior to this incident where the student ingested shower products while in the bathroom, and in another incident attempted to wrap a cord around his or her neck then ran from staff stating he or she was going to jump over the balcony on the second floor of the residence. The student then expressed to staff that he or she wanted to be hospitalized. Further, one and half months before this window jumping incident, the student left a suicide note that was found by staff. The student was placed on “close watch” after staff discovered the note. The student also requested to go to the hospital after this incident. Residential notes reflect the student then expressed feeling hopeless and expressed suicidal ideation. Six days before the student jumped out of the window, the student told staff that he or she should just die. Five days before the incident, the student again told staff that he or she did not want to live anymore. DLC did not find any documentation that the student was placed on close watch after making these comments. Lastly, the hospital where the student was treated after the incident found the student needed care and an inpatient stay after being medically cleared. As a result, DLC finds it concerning that the student was not assessed as a suicide risk. According to the review of the records, Chamberlain did notify EEC of the incident, but DLC did not find any record that EEC

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<sup>2</sup> In order to protect the students’ privacy, DLC has made all references without identification of the students’ gender.

investigated this incident. DLC did not find records that Chamberlain conducted an internal investigation following this incident.

## Student 2

Five months after the above incident, another student jumped out of the very same bathroom window as the student in the example above. This student also had a history of self-injurious behavior and suicidal ideations, including some while at Chamberlain. DLC found in the student's records that one of the student's outside providers wrote a letter stating this student requires constant supervision to ensure the student's safety. However, DLC only found one time that the student was placed on "close watch" status, and this was more than a year before the jumping incident. DLC was not able to find the "close watch" plan in the student's file, only notes in the residential log and school log that report the student was on "close watch" status. It is not known from the records why the student was placed on "close watch" at that earlier time. There were several incidents of suicidal ideations and self-harm attempts where the student was not placed on "close watch."

The day this student jumped, he or she had multiple outbursts earlier that same day. In their notes, staff described the student as very emotional that day. Despite these facts, DLC finds it concerning that DLC was unable to find any note that the student saw his or her therapist on the day he or she jumped, nor was DLC able to find documentation that the student was placed on "close watch" status. The student also left a suicide note in the bathroom before jumping out the window. This student was transferred to a Boston hospital by medical helicopter following this incident and sustained serious, lifelong injuries. Again, a record review reflects that Chamberlain did notify EEC of the incident, but DLC did not find any record that EEC investigated this incident. DLC also found that Chamberlain notified DESE of this incident. Notes by staff indicate that only after this second incident did Chamberlain adjust the window opening. DLC did not find records that Chamberlain conducted an internal investigation following this incident.

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## Student 3

A student jumped off a second story fire escape at a residence while reportedly being watched closely by staff. This student also had a past history of suicidal ideations and hospitalizations. A couple of months before the student jumped, the student had told staff that he or she was contemplating suicide. This student's records show that his

or her team at Chamberlain met almost one month to the day before he or she jumped to discuss his or her suicidal ideations. In this meeting, Chamberlain notes that the student is unable to make any consistent progress recently due to ongoing emotional crisis. Yet, despite these facts, the student was never placed on “close watch” status the entire time the student attended Chamberlain. Under the School’s policies, it would seem that having suicidal ideations would meet, at the very least, the close watch standard discussed above -- if not the suicide “at risk” policy in such instances.

Additionally, three weeks prior to the jumping incident, this student had run away from the school and was found by police. The student left the residence by using the same fire escape from which the student later jumped. There was no alarm on the fire escape at that time. The student was found by police and brought to the local hospital after making suicidal comments to the officers. The local hospital sent the student back to Chamberlain. The student was not placed on “close watch” status at that time.

In the day before the student jumped, the student’s parent had been calling staff about concerns the student was accessing non-approved material on the internet including social media sites. Even though this student was not on “close watch” status, staff was reportedly checking on the student frequently leading up to the incident. If the student had been on close watch status, staff would have been required to have the student in sight at all times during the day and evening. Chamberlain’s internal investigation references a video that reportedly shows staff checking on the student five times in the 30 minutes prior to when the student jumped. Just prior to jumping, the student reportedly called out to staff, who was in the TV room down the hall, saying he or she was going to kill themselves by jumping. The staff member was reportedly too far away to get to the student in time before he or she jumped. There was no alarm on the fire escape door at this time. After jumping, this student was transported to the local hospital for medical treatment before being transferred to a Boston area hospital for further medical and treatment. This student sustained serious injuries.

Chamberlain investigated this incident and found that they provided appropriate supervision and that they did not have any warning the student would jump. There was no corrective action plan issued. In addition to the concerns that the student was never placed on “close watch” and that there was no alarm on the fire escape door, it is concerning to DLC that staff notes did not address the fact that the student attempted suicide, but instead state that the student was transported to the hospital due to being upset about the denial of social media access and not leaving the program. DLC feels this minimizes the seriousness of the issue. EEC investigated this incident and found that there were no regulatory issues and no remedial plan needed.

## Other Incidents

### Student 4

Another student ingested bleach and was transported to the hospital. This student was upset and had originally put a bag over his or her head, but was stopped by staff.

After staff took the bag away, staff let this student go into the bathroom on his or her own where the student was able to ingest the bleach. Significantly, this was not the first time this student ingested bleach. About six months prior, the student had locked him or herself in the bathroom and sprayed bleach into his or her mouth. It is particularly concerning that this student had previously used bleach to self-harm and that the school had not established more specific protective measures such as ensuring that cleaning products like bleach were removed, or that such products were securely locked away from the students. This student had also previously attempted to jump out a window at the school, but was stopped by staff.

#### Student 5

Another student ran from campus and jumped into a river nearby while repeatedly saying “goodbye” to staff who were nearby. This was the second incident in a couple of weeks involving this student attempting to jump or jumping into the river. In the first incident, the student went out of a bathroom window in the residence and made it to the river before staff was able to stop him or her from jumping in. The student was hospitalized after this incident and, when he or she returned to campus, Chamberlain did not create a written plan to help prevent future incidents. The student then left the residence within a week of returning to campus and did jump in the river this time. Although a staff person jumped into the river to attempt a rescue, it was not successful. The student had to be rescued by the Fire Department by boat. EEC did investigate this series of incidents and found non-compliance.<sup>3</sup> EEC found that Chamberlain subsequently responded to each of the compliance issues satisfactorily.

#### Student 6

There are many examples where Student 6 made self-harm or suicidal threats over the weekend but then was not assessed by a clinical staff until Monday. As Chamberlain explained to DLC, clinicians only work typical school hours. There is an on duty residential supervisor and on call administrator that staff can call if they have mental health concerns about a student. The on duty supervisor is not a clinician. The administrator on call may be the clinical director, but is not always the clinical director. The administrator on call can then make the decision of whether they should call the psychiatrist to discuss hospitalizing a student. However, DLC rarely found records that staff utilized the on call system, and often the non-clinical, residential staff were addressing these mental health issues and sometimes incidents of serious self-injurious behavior with the students before the students were assessed by a clinician the next business day.

For example, there was one Saturday when Student 6 self-harmed even though he or she was on “close watch” status. Student 6 then told staff that he or she needed help due to mood swings he or she can’t control and that the student felt he or she needed

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<sup>3</sup> This incident is discussed in more detail in the “Inadequate Supervision” Section, IV,B.

more support to be safe. Then, the following day on Sunday, despite being on “close watch” status, the student attempted to choke him or herself, and said he or she wanted to die. The student was not sent to the hospital on either day, and records show the student did not see his or her therapist until Monday. DLC did not find records that the on-call administrator was called. Another time, the student told staff he or she was suicidal and needed to go to the hospital. Staff did not send the student to the hospital, DLC did not find records that an on-call administrator was contacted, and the student was not assessed by the therapist until the following Monday which was a full two days after this incident.

As part of Chamberlain’s self-injury plan and policy, they keep sharp objects such as knives and scissors locked up. However, this student was repeatedly finding broken glass under the residence deck or surrounding the residence. This student then would use the glass to self-harm. He or she had 37 documented incidents of self-harm while at Chamberlain and was hospitalized 13 times.<sup>4</sup> This student had to go to the hospital six times for stitches following self-injurious behavior, one time even receiving eleven stitches. DLC also found a pattern with this student where he or she would tell staff they needed to go to the hospital, staff would not send him or her, and then an incident would occur and the student would end up hospitalized anyway for harming him or herself or others.<sup>5</sup>

DLC found this occurring in the student’s records several times. For example, the student once required hospitalization after cutting him or herself with glass that required six stitches, and ended up being hospitalized for seven days. The student had told staff the day before this incident that he or she needed to go to the hospital. Another time the student said he or she wanted to go to the hospital because he or she wanted to kill themselves. Staff convinced the student to go on a field trip instead. Then the student cut him or herself on the field trip. Staff requested immediate assistance from a supervisor but were told to wait for word from management. The student later talked to management and was taken to the hospital via ambulance where he or she stayed for several days.

One day the student asked to go to the hospital as he or she was leaving campus and going into the woods. Staff refused to discuss this until the student came back to campus. The student then proceeded to walk into the woods until he or she was 1 mile from campus and cut him or herself extensively on the arms, legs, hands, feet and face. The student then reportedly attacked staff multiple times when they tried to restrain him or her and bring the student back to campus. The student reportedly punched, bit and attempted to choke staff. Chamberlain did not send the student to the hospital after this incident, nor did DLC find records that the student was put on “close watch” status. The residential notes from this date also note that the student had

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<sup>4</sup> This student did attend the school for many years. However, in one year alone, this student had sixteen documented incidents when he or she cut themselves.

<sup>5</sup> There were many other times the student requested to go to the hospital. We are not including every incident, only ones that were serious and not assessed.

suicidal ideations. Then, about one week after this first incident, the student again escalated and attempted to assault staff. It was not until after this second incident that the student was sent to the hospital where he or she remained for twelve days.

### Student 7

Another student was also frequently finding broken glass and other sharp materials surrounding the residence. This student then would use the glass and other objects to self-harm. This student, who has a long history of self-cutting, was left in the bathroom for 20 to 30 minutes in two separate incidents that occurred within two weeks of each other. In both incidents, a staff person was outside the bathroom the whole time and suspected the student was cutting him or herself. Each time, this student had cut him or herself repeatedly while in the bathroom. DLC did not find documentation that the student met with his or her therapist following these incidents, or that the student was put on “close watch” status.

Also, with many of these self-injurious occurrences, this student did not see his or her therapist until the following day, similar to Student 6 in the example above. This student put a seatbelt around his or her neck on two separate occasions while staff was driving. A non-clinical staff person then “processed” with him or her. DLC did not find any notes that the student talked to the therapist following these incidents. This student also had an incident where he or she had a knife and then, later in the day, wrapped a curtain around his or her neck. The student was not assessed by his or her therapist until the next day. Another example is a day when staff noted this student was acting strange. The student had poured shampoo all over the bathroom, self-injured, and was found sitting on his or her bed with his or her hands covered in blood. There was blood on the window sill in the bathroom. DLC did not find any records that an on-call administrator was called, no record that the student was evaluated by his or her therapist, and no record that the student was put on “close watch” status.

DLC did find records that show what had been an appropriate response by Chamberlain. This student escalated one day and assaulted his or her teacher. After the student calmed down, he or she met with his or her therapist, and put on “close watch” status. The student also met with his or her psychiatrist two days later.

Chamberlain reports they created their policy related to self-injurious behaviors with the help of a well-known expert. Part of this plan requires staff to ignore or not overly react to a student’s self-injurious behavior in order to not provide the students with the secondary gain or attention they are seeking.<sup>6</sup> DLC understands this strategy, but remains concerned about things such as the pervasive presence of broken glass that is accessible on the campus. Chamberlain informed DLC that students who want to find broken glass will find it and that sometimes it bubbles up from the ground from

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<sup>6</sup> Chamberlain reports it is their policy for staff to provide the students with first aid or a visit to the nurse if needed.

years ago. Chamberlain also reported that when students break windows, maintenance will clean it up immediately. DLC is concerned that Chamberlain appears to minimize the nature or seriousness of the student suicide attempts by not classifying them as suicide attempts. DLC understands that it is not possible to always prevent self-injury or know the precise mindset of a student, but DLC is concerned that many of these students are having serious self-injurious behaviors and suicidal ideations and not being assessed by clinical staff. Instead, students are assessed by non-clinical staff if it is after school hours or on weekends. It is also concerning to DLC that students were having these behaviors and ideations and yet not put on “close watch” or even assessed for “close watch.” An additional concern involves the failure of CIS to establish or create an appropriate individual program or treatment plan to address these significant needs for each student.

DLC understands that it is not possible to always prevent self-injury or know the precise mindset of a student, but DLC is concerned that many of these students are having serious self-injurious behaviors and suicidal ideations and not being assessed by clinical staff. Instead, students are assessed by non-clinical staff if it is after school hours or on weekends. It is also concerning to DLC that students were having these behaviors and ideations and yet not put on “close watch” or even assessed for “close watch.”

#### B. Inadequate supervision enabling students to run away

DLC received complaints that, due to inadequate supervision of students by Chamberlain staff, students had been able to run away from the Chamberlain School campus, resulting in actual or potential harm to the students. DLC investigated this allegation by reviewing the school records of approximately twenty students, talking to students and parents, obtaining and reviewing records from the Middleboro Police Department (MPD) and reviewing documents from the Department of Early Education and Care (EEC). After completing its investigation, DLC found that there was a significant number of instances of students being able to run away from the Chamberlain School campus, validating the concern that there was inadequate supervision of the students by CIS staff. The following examples illustrate the problem of inadequate supervision resulting in a failure to provide a safe environment:

- One student walked off campus and was found by staff at a traffic rotary, where several major highways intersect, almost three miles away; the same student ran away and was returned to the CIS campus by police; that same student ran away from the School and into the street, where there were multiple cars coming; and that same student, when on a school field trip in Boston, disappeared and was not found for over three days;
- One student ran into the woods and, after threatening to hurt staff, ran into the road. Because the staff was not watching him or her, the same student managed to leave

the CIS campus and, by hiding in a nearby barn, was missing from 4:30 pm until 11 a.m. the next day – the student was only found through the use of the police canine unit and an amber alert; the same student had approximately 22 different incidents where that student either ran into the woods, into the road, or to another location off campus;

- According to a state investigation and report, one student had climbed out of a bathroom window and ran from the campus, but when staff went outside to look for the student, they were unable to find the student for 20 minutes and called police for assistance. One hour after the student left the building the student was found under a bridge, next to a river. That student had taken off his/her shoes and was about to jump into the water, when the student was stopped. The student was taken by ambulance to a hospital for evaluation. The student was hospitalized for two weeks. Less than one month later, when that same student was back on campus, he or she refused to go to class, walked around the campus and wound up going into a maintenance shed that had been left unlocked. Staff convinced the student to return to school, but the student refused to go to class. The student ran from campus later that day. Multiple police departments were called, and the student was found by the police and returned to campus. Later that very same day, the student got away a second time, ran down the road and into a nearby field, and towards the tree line at the far end of the field, behind which is a river. That student was standing in the river, dunking his/her head in the water and repeating “good bye.” The student began to float down river towards the bridge, where the student was ultimately rescued by a first responder in a kayak.
  - After an investigation of the incident by EEC, a report was issued that expressed a number of concerns about this incident, including: (a) it found it concerning that despite the fact that the same student had attempted to jump into the same river only sixteen days earlier, which resulted in a two-week hospitalization, no safety plan was implemented to prevent the student from leaving the campus or from heading toward the river upon the student’s return to the school; (b) the agency also found disconcerting that there was no general safety plan in place by which staff are informed of geographic risk areas, such as the river; (c) staff who were monitoring the residence on the day of the second river incident stated they were not aware of any prior incident in which the student had attempted to injure him or herself or attempted to jump into the river, despite the fact that the student had only returned six days earlier from the hospitalization resulting from the prior river incident; and (d) the absence of a preventative plan authorizing staff to physically intervene was also a concern identified by the agency. As explained by the agency, although attempting to reduce restraints is admirable, when a resident’s pattern of behavior puts a

student at risk of harm, a preventative plan must be in place. Once a resident has attempted a particular methodology to self-harm, an individual safety plan needs to be developed to protect that resident from engaging in that particular behavior.

- CIS was directed to ensure that a team will identify residents' needs and develop individual service plans for meeting those needs, including safety and behavior management needs. CIS was required to explain all service plans and updates to all staff providing care to students and responsible for implementing the service plan on a daily basis. CIS staff should also be aware of the path of the river and woods and instructed to remain cognizant of the potential risk of those areas to residents in emotional distress. Subsequently CIS did respond satisfactorily to each of those outstanding compliance issues.
- One student ran out of the house, could not be located, so CIS called the police. The student was not found for over 90 minutes; that same student ran out of the house with another student and when the student was not found the police were called, but the student was not located for 45 minutes; the same student ran out of class, into the woods and when the student was found the student had multiple scratches due to briars in the woods; the same student ran out of the house, CIS staff searched for him or her in a vehicle and he or she was found later heading north on Route 18; on a different day that same student rode off on his or her bike away from his or her 1:1 aide and onto Route 495. After the student was missing for 20 minutes CIS called the police who found the student three hours later.
- One student ran out of the residence a significant number of times, at least 12 of which involved leaving the residence and going either into the woods, the road, a field, another building on campus or to a van where the student locked him or herself inside of the vehicle. One student ran from the school and was AWOL for a day.

When DLC discussed the issue of inadequate supervision which allowed students to run away from the CIS campus, the School responded that it was the unfortunate consequence of having an open campus. The school further suggested that they would be unable to physically restrain a student from leaving the campus, even if it might result in the student getting into harm's way. While one can certainly appreciate the challenges presented by having an open campus in such a setting, where woods, fields and a river are nearby, the pattern of multiple escapes and runaways, particularly with respect to certain students who have exhibited such patterns repeatedly, imposes upon the school the obligation to take reasonable and effective protective measures. As

EEC has noted in its report, when a resident's pattern of behavior puts a student at risk of harm, a preventative plan must be in place. After a resident has attempted a particular methodology to self-harm, an individual safety plan needs to be developed to protect that resident from engaging in that particular behavior. As further noted by the licensing agency, if staff members were not made aware of prior similar actions done by a student, then the school has failed in its obligation to keep its staff informed of such essential information. The failure to establish and maintain an adequate level of supervision and undertake effective steps to reduce or eliminate such risks results in an unsafe environment for students, exposing those students to actual or potential harm. This constitutes "neglect" under the PAIMI regulations.

The failure to establish and maintain an adequate level of supervision and undertake effective steps to reduce or eliminate such risks results in an unsafe environment for students, exposing those students to actual or potential harm. This constitutes "neglect" under the PAIMI regulations.

### C. Medication Issues

DLC received allegations about medication errors and the improper administration of medication. DLC first received such complaints in May of 2015, and then subsequently received additional complaints during the course of its investigation. DLC investigated this by reviewing twenty student records and talking to over two dozen students and parents. After completing our investigation, DLC found several errors in administering or failing to administer medication to students. DLC would note that Chamberlain does administer a lot of medication to over 100 students without any error<sup>7</sup>, however, the errors that DLC found are concerning for student health and safety. Remedial action is necessary to prevent similar issues in the future, and as noted below, some improvements are already underway. Here are some examples of medication errors that were found:

- One student was mistakenly not given his or her anti-depressant medication for over two months. This was only discovered after the student required hospitalization following the two months without medication. It was determined that the pharmacy failed to send the medication to Chamberlain. Chamberlain reports it added additional procedures and safeguards after this incident.
- One student was found unresponsive and sent to a local hospital before transferring to a hospital in Boston for four days. It was discovered the student had a strong anti-psychotic medication in his or her system that had not been prescribed for that student. It is unclear how the student got this medication,

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<sup>7</sup> Chamberlain reports that it has an overall 0.01% error rate in administering medication.

however there was at least one student in the school who was taking this particular medication at that time.

- One student was mistakenly given his or her dose of medication twice within 30 minutes. One staff person administered the medication early but failed to note that he or she had done so. After the shift change, another staff person administered the medication at the regular time not knowing the student already received the dosage since the prior administration of medicine had not been documented. The student then became extremely tired, was seen by the school nurse, and was sent to the hospital.
- One student received four times his or her prescribed dosage of psychiatric medication seven times in a three week period. The student was originally receiving three pills at 25 mg (75 mg total). The doctor then increased the dosage to one, 100 mg pill. Some staff however continued to think that the student was getting 25 mg pills due to an error on the medication administration record and thus gave the student four, 100 mg pills in error. This added up to a total of 2100 mg of extra medication that was mistakenly administered to this student.
- One student was sent home for a school break without any medication including seizure medication. The student realized this several days into the vacation after reportedly having a seizure and notifying Chamberlain.
- A different student was also sent home for a break without his or her medication.
- Another student was sent home for a school break with the wrong medication.
- DLC found notes in several students' files where medication was not available for several days.

In response to concerns about the medication errors, Chamberlain has taken a number of remedial steps. Chamberlain has informed DLC that it has decided to hire additional nurses to administer medication on nights and weekends. Chamberlain reports its intent is to only have licensed nurses administer medication instead of lay staff and reports that it has already posted advertisements for these jobs and started interviewing candidates. Chamberlain also made a staffing change and is set to have a new Director of Nursing start in September. Once this new nurse starts, Chamberlain plans to review its staff training procedures, packaging of medications and other protocols. DLC believes these steps will help avoid future mistakes and errors.

#### D. Bullying

One of the recurring complaints DLC found during its investigation was peer on peer bullying. DLC found evidence of this in student records and also received complaints about bullying from multiple students and parents. Massachusetts regulations define bullying as follows:

the repeated use by one or more students of a written, verbal or electronic

expression or a physical act or gesture or any combination thereof, directed at a target that:

- (a) causes physical or emotional harm to the target or damage to the target's property;
- (b) places the target in reasonable fear of harm to himself or herself or damage to his or her property;
- (c) creates a hostile environment at school for the target;
- (d) infringes on the rights of the target at school; or
- (e) materially and substantially disrupts the education process or the orderly operation of a school. Bullying shall include cyberbullying.

603 C.M.R. § 49.03

DLC found extensive documentation that one student repeatedly reported to staff that he or she was bullied. This happened over several months before the records show documentation that staff met with this student to discuss the bullying. The student first told staff that other students were constantly making derogatory comments to him or her. Then three days later the student reported to staff that he or she was being bullied. Four days after that, the student told staff he or she continued to be bullied at school. Two days later, this student told staff he or she was anxious because he or she continued to be bullied at school and other students were spreading rumors about him or her. The next day, the student's parent called Chamberlain about this bullying. A few weeks later, staff noted that the student was on the phone with his or her parent and was crying telling the parent that other students were calling the student names and saying he or she was the ugliest person on campus. Two days after that phone call, the student told staff that a particular student was targeting him or her. Six days after that, the student reported that the same student was targeting him or her and telling people not to be friends with him or her. The following day, the student reported to staff that this same student called the student derogatory names in class. Five days later, staff note that other students were writing mean things about this student on a school table. The next day the student again reported that the students were again bullying him or her and stole his or her hat at lunch. It was only at this point, almost two months after initially reporting the bullying, that the records reflect staff finally sat down with this student to address the bullying.

DLC finds that Chamberlain did not follow the Massachusetts anti-bullying law and regulations in the above instance. DLC found records that staff reported these reports of bullying to a supervisor in one of the instances explained above. DLC did not find records that they were reported in the other instances. Chamberlain's bullying policy requires that all reports of bullying should be made to the Program Director. Further, its policy requires that staff "report any rumors of bullying." (Emphasis in original). Staff are also required to complete a written incident report if they receive information about bullying or witness bullying. DLC did not find any records that these instances were investigated to determine if bullying had occurred and, if so, what the school could do to stop it and what services they could offer to help the student. These

are all required actions under the Massachusetts anti-bullying law, which states that schools must promptly report and investigate reports of bullying.

DLC also reviewed two other students' records where it found dozens of bullying incidents where these two students were the bullies, but did not find any bullying investigations or any specific plan to address and reduce these behaviors.

Another student reported that he or she was continuously bullied by one student in his or her residence. This bullying reportedly included statements with anti-Semitic slurs. The student reported this to staff, yet felt staff did not do anything to stop the bullying. The student was then physically attacked and had to change residences after this incident. When these incidents were raised with a Chamberlain administrator, he or she reportedly said that the alleged victim had started the fight. In this case, the reported incident would qualify as both bullying under Massachusetts law and discriminatory harassment under federal law.

DLC found many other examples of bullying at the school. Here are additional examples:

- One student had three classmates put feces on his or her pillow. The student reported to staff that these three classmates had been picking on him or her. This same student was later physically assaulted by other students twice in one week. This student reported he or she had to move residences more than once due to bullying.
- Yet another student had over twenty concerning bullying incidents as recorded by staff. The student was choked by one peer, and the same peer also made multiple threatening comments to the student. This student was often the target of physical attacks by peers, was slapped by peers, and verbally targeted by peers. The student's parent even reported to staff that other students were making anti-Semitic comments while the parent was there on a visit. The student reported to staff that he or she was being bullied, but DLC could not find evidence of follow up by the school. Further, there was no evidence in this student's file that Chamberlain ever conducted a bullying investigation.
- One student was repeatedly called fat by classmates. This student had a history of being bullied at his or her previous school. The student later saw graffiti in the bathroom discussing him or her. The student's parent also contacted Chamberlain staff to report his or her concerns that their child was being bullied. Records show that this student spoke to his or her therapist about the bullying and that the therapist encouraged the student to ignore the other students as a coping mechanism. DLC did not find any records of a bullying investigation by Chamberlain.

Since there are a significant number of concerning incidents and no record of investigations having been done, DLC finds Chamberlain's lack of response to such bullying constitutes a failure to provide a safe environment and thus meets the definition of neglect under the PAIMI regulations. Further, DLC finds that Chamberlain did not follow Massachusetts law related to bullying both in their actions and policy.

**Chamberlain must broaden its view and definition of what constitutes bullying, aligning it with Massachusetts law and take timely and effective proactive and remedial actions to stop bullying on its campus.**

DLC did discuss its bullying concerns with Chamberlain. Chamberlain responded that they do have an anti-bullying policy, but that many of these incidents were not bullying because there was no imbalance of power between the students. Chamberlain's written Bullying Policy also reflects this narrower view of what constitutes bullying, citing an imbalance of power. As made clear by the regulatory definition of bullying cited above, Chamberlain's much narrower construction of bullying is not the full scope of what constitutes bullying under Massachusetts law. Chamberlain must broaden its view and definition of what constitutes bullying, aligning it with Massachusetts law and take timely and effective proactive and remedial actions to stop bullying on its campus. In addition, Chamberlain's bullying policy states that "the administration will investigate all reports/complaints where appropriate." DLC finds this part of the policy is too broad. There is no definition of when a complaint is appropriate and this gives the administration too much discretion about whether they have to investigate a bullying allegation. As described above, this has resulted in no bullying investigations in the sample of records DLC reviewed, despite many bullying complaints. This part of Chamberlain's policy must be fixed.

#### E. Restraints

DLC originally received complaints in May of 2015 regarding inappropriate and excessive restraints at the Chamberlain School. Throughout its investigation, DLC continued to receive additional complaints of inappropriate and excessive restraints, as well as restraints using excessive force. State law provides protections to prevent children from being unlawfully physically restrained while attending school. Under 603 CMR § 46.03, physical restraint can only be used when non-physical interventions would not be effective and should be considered "an emergency procedure of last resort." *Id.* In addition, the student's behavior must pose a threat of imminent, serious, physical harm to self and/or others. Physical restraint cannot be used as a means of punishment. Nor may it be used as a response to property destruction, disruption of school order, a student's refusal to comply with a school rule or staff directive, or verbal threats that do not constitute a threat of imminent, serious, physical harm. These laws exist to protect all children and specifically to protect children with disabilities.

In the course of its investigation, DLC found evidence of inappropriate or excessive restraints at Chamberlain in student records and student and parent verbal complaints. Here are some examples that illustrate DLC's findings:

- One student had over 50 documented restraints in a 24 month period.
- Another student had 116 restraints in the 36 month period of the records DLC reviewed.
- School records indicate that staff used excessive force when one student was pushed back on the couch and subjected to a seated hold. The student reported that he or she was thrown on the couch, then taken off camera, punched in the leg, thrown against the wall and held there.
- Another incident of excessive force involved a staff member putting his or her hands on a student's neck. DLC also found a similar incident with a different student. This different student reported to the Chamberlain nurse that he or she was grabbed by the neck. The nurse noted "two visible reddish blue straight lines areas on left side of neck." The next day the nurse noted early bruising in the area. DLC did not find any records that this was reported to DCF or EEC.
- A student complained that staffed pinched him or her. The student was observed by the school nurse to have "fresh, finger-sized bruises" on his or her left torso. These bruises were observed both on the front and back of the student's torso. The student also had a rug burn under his or her armpit with a bruise around it about 2 inches by 4 inches. Chamberlain did report this to DCF and also conducted an internal investigation. This staff member, who had a previous disciplinary warning, was terminated.
- Chamberlain nursing records note one student had two inches of broken capillaries on the front of his or her neck following a restraint.
- Records show that a student fell backwards while being restrained and hit his or her head on the floor. The student also had marks on his or her chest and both shoulders after the restraints including broken blood vessels.
- One student was put in a physical escort by two staff because he or she was unresponsive to staff requests. This then triggered the student who escalated and was then put in a prone restraint for 15 minutes. After the restraint began, the student became combative. This was an inappropriate reaction to this student because it was well documented that the student was triggered by physical touch. Further, it was well documented in the records that physically touching was a trigger for further escalation for this particular student. The student also informed staff of this trigger. The student then fell to the ground in the restraint and was put in a prone restraint for 10 minutes. The student continued to bang his or her head on the ground, sustained wounds, and needed to go to the emergency room. This same student was restrained and physically directed many times despite the documentation that this was a clear trigger. The student was restrained after becoming aggressive when staff put hands on him or her when the student was not listening to staff instructions. This restraint

lasted for 10 minutes. As a remedial measure, the staff person was required to review restraint protocol after this incident. Another incident involved staff physically escorting this student. The student then escalated and staff report they had to bypass a team control hold and go immediately to the prone restraint position. Yet another time, this student was restrained in the supine position for 10 minutes because he or she did not want to get in the van and then began to walk to a dorm. There was another incident when staff touched this student's shoulder to give directions and this again triggered the student and ended in a restraint. This student was involved in another questionable restraint. He or she was not following directions. When the student finally complied and got up to move to the other room, he or she struck staff. There is no documentation that the student continued to escalate beyond this one action, was out of control, or that there was an ongoing safety issue. However, staff still initiated a three person, supine hold that lasted for fourteen minutes.

- DLC found one parent consented to restraint only when the student met the definition of a run away, yet the student was restrained many times when he or she did not meet the runaway criterion.
- One student reported getting slapped in the face by staff while being restrained. The staff then reportedly asked other staff to take over the restraint so the staff would not do something to get themselves fired.
- One student reports witnessing a restraint of a peer where the peer was restrained, pushed on his or her stomach on the sidewalk, and then threw up.
- One student reported that some staff are rough when they restrain him or her and that the restraints are painful. The student reports having his or her arm pulled all the way back behind his or her back, getting pinched by staff during a restraint, and not being able to breathe while in a restraint.
- One student was restrained after assaulting staff. The restraint resulted in the student's face being swollen and red. The student also complained that his or her whole body hurt. There was no incident report related to this incident in the student's records, nor did the residential notes mention it. There were only notes from the nurse and a summary of the incident from a fax to the student's home school district.
- One student reported seeing a staff person grab a student by the back of the neck and knee the student in the back. The staff person reportedly threatened to punish the student if the student reported the incident.
- Another student reported seeing a restraint where the student's face was pushed into the rug and the student sustained a rug burn on his or her face.

Another incident of excessive force involved a staff member putting his or her hands on a student's neck. DLC also found a similar incident with a different student. This different student reported to the Chamberlain nurse that he or she was grabbed by the neck. The nurse noted "two visible reddish blue straight lines areas on left side of neck." The next day the nurse noted early bruising in the area. DLC did not find any records that this was reported to DCF or EEC.

Overall, DLC found evidence of excessive and inappropriate restraints at Chamberlain that meet the definition of abuse and neglect under 45 C.F.R. § 1386.19; 42 C.F.R. § 51.2. As illustrated above, DLC found many examples where staff at the Chamberlain school did not comply with Federal and State laws. Many of these findings are based on incidents that happened before Chamberlain started implementing their new behavior management system, CPS.

The Chamberlain School informed DLC that they started the process of going restraint-free in the fall of 2015. Chamberlain provided DLC with information on the new program they are using called Collaborative Problem Solving (CPS). Chamberlain reports that this program change has been approved by its licensors. As a result of this change, Chamberlain had to arrange for alternate programs for seven students who they felt could not work with the new program without restraints. According to data from Chamberlain, they fully implemented the CPS system in January of 2016 and between then and June of 2016, they only used restraints in nine instances.

Chamberlain is moving forward with making the school restraint free and consulting with an expert in CPS to help make this happen. DLC finds it is commendable that Chamberlain is attempting to remedy these issues by going restraint free, but DLC is concerned that, while the administration appears committed and knowledgeable about the restraint-free techniques, it might be difficult to change the culture of the staff from frequently restraining students to a more cooperative and collaborative environment.

#### F. Inappropriate Staff Behavior

In the dozens of parent and student interviews DLC conducted, DLC received many complaints about verbal abuse by staff and other inappropriate staff behavior. DLC finds much of this behavior meets the definition of abuse under the federal regulations.

DLC is also concerned about this behavior contributing to a negative culture in the school for both staff and students, as well as being contrary to the therapeutic environment and treatment the school wishes to establish. Here are some examples of the complaints and reports DLC received, which were found to be credible:

- DLC received information of an incident where a staff person tried to physically attack a student after the student splashed soda on the staff member. Two other students had to physically hold the staff person back. The staff member told the students that if they did not hold him or her back, the staff person would have “beat the s\*\*\*” out of the other student.
- A staff told other students that he was going to “f\*\*\* that kid’s [referring to one of the students in the house] mom and not use a condom” so that the student would have to see the staff member’s face when he or she sees the child of his or her mother and the staff member. DLC discussed this complaint with Chamberlain. Chamberlain reported that they interviewed this staff member and several other staff members and that no one reported concerns or previous complaints about this staff member. Chamberlain did not interview any students in the house where this incident reportedly happened. Chamberlain asked DLC to provide the name of the reporter so that they could identify which students to interview. DLC did not provide the name of the reporter, as DLC is required by federal law to keep the identity of the reporter confidential. DLC has found this reporter’s information to be accurate in the past, and has no reason to suspect that the reporter is fabricating or embellishing this incident.
- DLC received a report from someone who witnessed a male staff go into a female student’s bedroom and then drag the student off of her top bunk-bed because the student was refusing to leave her room. According to the witness, male staff are not allowed in female students’ bedrooms. The witness reported this to staff and staff reportedly said there was nothing they could do because the staff person involved in the incident was a supervisor.
- DLC received a complaint that a student was crying on the phone to his or her parent when a staff member told the student to “shut up and be quiet.” The staff member then ended the phone call between the student and the parent.
- We received more than a dozen complaints of staff swearing at students. Here some specific examples:
  - Staff tell students “I’m going to drop your a\*\*\*” or “I’m going to kick your a\*\*.”
  - Staff told a student that “I don’t give a s\*\*\* about you, I’m only here to get paid.”
  - Staff told a student that the student’s “a\*\* belongs in jail.”
- One administrator told a student they would end up in prison or a mental hospital.
- DLC received a complaint that a student was called anti-Semitic slurs by a staff member. This same staff member then said in a meeting that the student was the worst behaved student in the house.
- DLC received a complaint that a staff member targeted a different student for his or her Jewish faith. Staff reportedly made holocaust jokes and told this student that he or she should “burn like a real Jew.”
- DLC received a report that staff are often condescending and have said “I don’t care how retarded that kid is.”

- Student reports about one house manager’s behavior towards the students is verbally and physically inappropriate, condescending and threatening. Two students reported that they told this to their therapists but said nothing changed. DLC discussed this concern with Chamberlain. Chamberlain informed DLC that they spoke with the staff member’s supervisor and the supervisor reported this staff member’s style did not fit with the needs of the students of that house. As a result, the supervisor reportedly moved the staff member to a different role. This staff member is still employed by Chamberlain, but works in a different area of the school.
- One staff member told another staff member in front of students that if he or she thought any of the students would ever have spouses, the staff member was as “crazy as they [the students] are.”
- Staff told a student with a phobia of showers that they were disgusting for not showering.
- Staff reportedly told a student “when you’re older and in prison, you won’t be able to speak because you’ll have a d\*\*\* in your mouth.” When a parent reported this to an administrator, the administrator reported that the staff had snapped because the students had bullied him or her so much.
- Staff wrote in an incident report that when a student would not comply with directions that the staff began to use a louder tone of voice with the student and even yelled at the student. The student then became agitated and the incident ended in the student being restrained.

DLC finds that these complaints meet the definition of abuse which includes “verbal, nonverbal, mental and emotional harassment.” 42 C.F.R. § 51.2. DLC had a general conversation with Chamberlain about verbal abuse concerns. Chamberlain informed DLC that verbal abuse is not tolerated, is strictly against their school policies, and would be reported to DCF if raised with staff. Chamberlain informed DLC that sometimes students misconstrue what staff are saying when they are joking, or that students get upset when staff members set limits or deny them privileges and students refer to this as verbal abuse. Further, Chamberlain informed DLC that sometimes certain students don’t understand colloquialisms. DLC finds that many of the complaints received do not fit within the explanation Chamberlain provided but do fit within the statutory definition of abuse.

## **V. Conclusion**

Many of the initial allegations were especially alarming, which precipitated and necessitated a thorough abuse and neglect investigation. During the course of the investigation, while the substance of some of those initial allegations was not supported by the evidence, other concerns were substantiated. In some of the issue areas, CIS has undertaken remedial steps and made personnel changes to certain senior staff positions.

As set forth in greater detail in the prior sub-sections of Section III, “Factual Findings,” DLC has found:

1. Neglect in the school’s failure to prevent and properly respond to students exhibiting serious self-injurious behavior;
2. Neglect in the school’s failure to establish and maintain an adequate level of supervision and undertake effective steps to reduce or eliminate risks from students running away from the school’s campus. This results in an unsafe environment for students, and exposes students to actual or potential harm;
3. Neglect in the school’s failure to investigate and stop bullying incidents and to comply fully with Massachusetts’ anti-bullying law, which constitutes a failure to provide a safe environment; and
4. Abuse, in the form of verbal, nonverbal, mental and emotional harassment, and other inappropriate treatment of students by staff.

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4. Abuse, in the form of verbal, nonverbal, mental and emotional harassment, and other inappropriate treatment of students by staff.

With respect to the other two issues: inappropriate and excessive restraints and the medication issues, DLC did find that past policies and practices had resulted in abuse and neglect of students, but CIS has undertaken substantive remedial measures since the commencement of the investigation. Most notably, in the area of restraints, the school has announced and undertaken an effort to make CIS a restraint free campus. As a result, the numbers of restraints have significantly decreased. Since the start of the Collaborative Problem Solving (CPS) program in January 2016, CIS reports that in most months, there has only been one restraint. CIS senior staff explained that the full implementation of that effort will require a several year period, but the initial results

certainly show promise. The school will have to work to change the culture of frequent restraints of students to transition to and achieve a restraint free campus.

In the area of medication administration, the school has announced remedial steps as well. CIS has stated its intention that all medication administration will be conducted by nursing personnel. CIS is currently working to hire a sufficient number of nursing staff. CIS has also changed senior management in the nursing department to more quickly address the concerns and move the nursing department forward.

Notably, there have been changes to other senior staff positions, including the Program Director, the Clinical Director, and Director of Student Life.

While recognizing that CIS has made very good progress in some issue areas, DLC does have concerns about the abuse and neglect at the school, as set forth above. CIS needs to formulate a remedial plan which addresses each of the above issues where neglect or abuse was found. That plan, which must be created and submitted to DLC by November 16, 2016, shall include the following elements:

1. Policies and practices to effectively identify, prevent and treat students who exhibit or are at risk of serious self-injurious behavior (which should include a plan to provide timely access to clinical staff on evenings and weekends);
2. Policies and practices to establish and maintain an adequate level of supervision and undertake effective steps to reduce or eliminate risks from students running away from the school's campus (which should include a plan to address the need for greater oversight of residential staff);
3. Policies and practices to establish an effective anti-bullying program, consistent with the requirements of the Massachusetts anti-bullying law;
4. Policies and practices to eliminate verbal, nonverbal, mental and emotional harassment and other inappropriate treatment of students by staff;
5. A process and timeline for periodic reporting to DLC on the continued progress in moving CIS to a restraint-free campus; and
6. A process and timeline for periodic Reporting to DLC on the continued effort to address medication issues.