

DISABILITY LAW CENTER INVESTIGATION REPORT

PECK SCHOOL, HOLYOKE, MASSACHUSETTS

I. INTRODUCTION

The Disability Law Center (DLC) is a private, non-profit organization mandated by Congress and designated by the Governor of Massachusetts to provide “protection and advocacy” services to individuals with disabilities, pursuant to the Protection and Advocacy for Persons with Developmental Disabilities Act, 42 U.S.C. §§1501 et seq., (PAIDD) and Protection and Advocacy for Persons with Mental Illness Act, 42 USC §§10801 et seq. As part of this mandate, DLC is authorized to investigate incidents of alleged abuse, neglect, and civil rights violations of persons with disabilities within the Commonwealth of Massachusetts.

On April 2, 2015, DLC received a complaint to the system regarding the treatment of children in the Therapeutic Intervention Program (TIP) at the Peck School in Holyoke, Massachusetts. This program is supposed to provide a therapeutic educational program for children in the 4th-8th grade with emotional and behavioral disabilities. In response to this complaint, DLC invoked its statutory authority as the Protection and Advocacy (P&A) system of Massachusetts to conduct an investigation. We acted pursuant to our concern that children with developmental disabilities and mental illness attending TIP are subject to abuse and neglect and improper practices.

On April 30, 2015, DLC sent Dr. Sergio Paez, the Superintendent of Schools in Holyoke, Massachusetts notice of our intent to investigate. That same week, the Board of Elementary and Secondary Education (DESE) declared the Holyoke Public Schools a chronically underperforming school system, Level 5, and took receivership of the District. As a result, Mitchell D. Chester, the Commissioner of the Department of Education (DOE), took temporary control of the District and in July of 2015, Dr. Steven Zrike, was named the permanent receiver for the district. After a comprehensive investigation, as the following report details, DLC found that the children in the TIP program have been subject to abuse and neglect, improper practices, and unsafe conditions. The District must take immediate corrective measures to prevent further harm to these children.

II. BACKGROUND

DLC began its investigation with a site visit on May 12, 2015. This included a meeting with Justin Cotton, the current principal of the Peck School, and Carol Hepworth, the Special Education Director. During this visit, DLC also conducted an extended tour of the building and took photographs. DLC staff returned on June 9, 2015 to interview 11 staff members and returned on June 12, 2015 to interview 9 additional staff members and conduct a second tour of the facility. DLC returned on November 10, 2015 for a fourth visit to the school to meet with Nancy Athas, the new acting principal, Ron McCoy, the assistant principal and Carol Hepworth, the special education director. During this visit, DLC took another tour of the building and viewed each individual TIP classroom. As part of this investigation, DLC requested extensive records from counsel for the school District. One record that counsel for the District produced early in our investigation was a comprehensive letter with attachments written by Liza Hirsch, a former employee of the Peck School¹. Ms. Hirsch had sent this letter to Sergio Paez, the former Superintendent of Schools, on March 6, 2015. This document outlined in great detail the concerning practices in the TIP program and multiple incidents of abuse, neglect, and conditions/practices that have put children at risk.²

In addition to Ms. Hirsch's report, DLC reviewed extensive DCF records involving staff at the Peck School, two years of school restraint records, the PQA complaint, findings, and closure letter, TIP restraint training certification records, logs from the intervention room, individual student files (including individualized education plans and evaluations), post restraint records completed by the school nurse, records completed by the Peck Restraint Evaluation Team, Peck Planning Team records, TIP program floor plans, School Works Action Plans and School Based Services Contracts.

DLC also interviewed over 45 students and guardians, employees of local social service agencies that service children attending the Peck school, attorneys involved with Peck students, and former Peck staff. During the time of our investigation, the Commissioner also visited the

¹ Liza Hirsch was an employee at the Peck School from August 28, 2014 through March 6, 2015. During her employment she made extensive efforts to improve the culture and reduce improper restraints at TIP. These efforts were documented in her letter and attachments that included email correspondence between Ms. Hirsch and the TIP administration.

² This letter was also submitted to the Department of Education (DOE) Program Quality Assurance (PQA) and was the basis for the complaint that PQA investigated independently from our investigation.

school as part of the receivership process and DESE received the Program and Quality Assurance (PQA) complaint regarding the TIP program. PQA then found non-compliance in all areas reported, including improper restraint and seclusion, and ordered corrective actions

During our November 10, 2015 visit to the school, administrative personnel reported that some corrective measures had recently been put into place to address our noted violations. This included contracting with an outside vendor to provide intervention services to TIP students. Since these changes are brand new, DLC has not been able to determine if these actions have or will correct the egregious abuse and neglect found in this program. This issue and further corrective action needed will be discussed at the end of this report.

III. LEGAL AUTHORITY

DLC, as the designated Protection and Advocacy System for Massachusetts, is authorized under the PAIDD statute “to investigate incidents of abuse and neglect of individuals with developmental disabilities if the incidents are reported . . . or if there is probable cause to believe that the incidents occurred.” 42 USC § 15043(a)(2)(b).³ Similarly, DLC is equivalently authorized under the PAIMI statute for individuals with mental illness. 42 U.S.C. § 10805(a)(1)(A). As noted above, this investigation was commenced based upon a “complaint to the system.”

The PAIDD and PAIMI regulations define the terms “abuse” and “neglect” in almost the identical language. For example, the PAIDD regulations define “abuse” as:

any act or failure to act 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 developmental disabilities, and includes such acts as: Verbal, nonverbal, mental and emotional harassment; rape or sexual assault; striking; the use of excessive force when placing such an individual in bodily restraints; the use of bodily or chemical restraints which is not in compliance with Federal and State laws and regulations or any other practice which is likely to cause immediate physical or psychological harm or result in long term harm if such practices continue.

45 C.F.R. § 1386.19. (The equivalent definition of “abuse” in the PAIMI regulations is found at 42 C.F.R. § 51.2.)

³ DLC has identical authority under the PAIR statute for individuals who do not fall within the PAIDD and PAIMI statutes. *See* 29 U.S.C § 794(e)(f)(2) (stating that P&A’s have the same investigation authorities for people who meet the definition set forth in 29 U.S.C § 794e(a)(1)(b) as the P&A has for people with developmental disabilities).

The PAIDD regulations define “neglect” as:

Neglect means a negligent act or omission by an individual responsible for providing treatment or habilitation services which caused or may have caused injury or death to an individual with developmental disabilities or which placed an individual with developmental disabilities at risk of injury or death, and includes acts or omissions such as failure to: establish or carry out an appropriate individual program plan or treatment plan (including a discharge plan); provide adequate nutrition, clothing, or health care to an individual with developmental disabilities; provide a safe environment which also includes failure to maintain adequate numbers of trained staff.

45 C.F.R. § 1386.19. (The equivalent definition of “neglect” under PAIMI is found at 42 C.F.R. § 51.2.)

IV. FACTUAL FINDINGS

A. Improper Restraint using Excessive Force

State law provides protections to prevent children from being unlawfully physically restrained while attending school. Under 603 CMR 46.04, physical restraint can only be used when non-physical interventions would not be effective. In addition, the student’s behavior must pose a threat of imminent, serious, physical harm to self and/or other. 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.

During DLC’s investigation, we found that TIP has a consistent practice of restraining children using excessive force for reasons that do not comply with the restrictions imposed by State and Federal laws. Throughout DLC’s investigation, the evidence collected supports the occurrence of these violations. During our interviews at Peck, over 10 current individual staff members reported concerns with the way that restraint is being utilized in the school. These concerns include but are not limited to the following:

- **Children being thrown to the floor for refusing to move.**
- **Children being pulled out of chairs for refusing to get up.**

- **Staff using a level of force beyond what is needed to resolve the situation.**
- **Staff tackling students to the ground and using prone restraint.**
- **Students being restrained resulting in injury for refusing to change into a uniform.**
- **Interventionists restraining children without utilizing any de-escalation techniques.**
- **Staff using prone restraint resulting in injury when it wasn't needed.**
- **Students being threatened with suspension for refusing to delete photographs taken during improper restraints.**
- **Interventionists stating that they conducted around 30 restraints this year and that they restrained for behavioral issues including defiance and throwing things.**
- **An authoritative attitude towards children “you do what I tell you or else”**
- **That it is hard to change the habit and pattern of improper restraint.**
- **A Student losing a tooth during a prone restraint.**

Prone restraints endanger breathing and may be life threatening, with children noted to be at especially high risk for death and serious injury.

See Miller, C., “Restraint Asphyxia: Silent Killer,” Residential Group Care Quarterly, Vol. 2 No. 4 (Summer 2001), pp. 1,8; and SAMSHA National Action Plan on Seclusion and Restraint, Revised and adopted May 2003.

During our interviews with students and guardians, we received over 20 egregious examples of improper restraint in violation of Federal and State laws. The reported incidents included, but are not limited to the following:

- **Students being thrown to the floor and slapped.**
- **Staff restraining students for refusing to leave their classrooms.**
- **Students feeling as if they cannot breathe during prone restraint.**
- **Multiple restraints resulting in scratches and bruises for not following the rules.**
- **Yanking on students arms to move them with such force that it leaves bruises and scratches.**
- **Staff sitting on students on the floor so that they can't see.**
- **Staff grabbing students with so much force that it leaves marks for refusing to get up.**
- **An interventionist slamming a student into the wall resulting in injury.**
- **Staff restraining a student for throwing food resulting in an injury to his head.**
- **A student being thrown to the ground resulting in scratches and bruises for not following directions.**
- **A child being punched during a restraint.**
- **Children being hit against the wall and children being pushed on the floor face down.**

One parent reported that her child, who weighed less than 100 pounds, was put into a prone restraint by three staff members and wound up with an injury to the youngster's head.

According to school records reviewed, one student was subjected to 50 restraints, including many that were prone. The student's parent reported that the youngster pleaded that s/he was unable to breathe and that on multiple occasions the student complained of pain as a result of the restraints.

A third family reported that a student was repeatedly restrained and, as a result, the student suffered an increase in anxiety and panic attacks.

DLC also spoke with staff members at local social service agencies who work with TIP students and families. Agency staff reported multiple instances of improper restraint and seclusion in the TIP program and stated that TIP staff use inappropriate interventions and treat children poorly. One local service provider stated that she meets regularly with TIP students and has never had to use restraint or any behavioral interventions. She said “I treat kids with kindness and I have never had a problem.” We also spoke with local attorneys who represent TIP students. All of these professionals expressed a deep concern for the restraint practices at TIP. They reported the culture of violence among the interventionists (as well as other staff) and that de-escalation measures are not consistently implemented before putting hands on children in an aggressive manner. They also reported that staff are physically aggressive with the students and when the students fight back they are arrested for assault. All of these concerns were presented in great detail in Liza Hirsch’s letter that became the basis for the PQA complaint. On July 21, 2015, PQA issued a Finding of Non-Compliance that was sent to Stephen Zrike, the Holyoke Public School Receiver. The PQA investigator reviewed approximately 170 restraint reports and other records submitted by the District and then found, “the District’s Local Report leaves unrefuted the complainant’s allegation that students were restrained for violating school rules or for disruptions of the school environment that did not constitute a danger to the students or others”.

The improper use of restraint at Peck has also been documented by the internal Peck Restraint Evaluation Team. DLC received some of the written reports completed by the Internal Restraint Evaluation Team. One report found that a restraint was improperly conducted stating “not necessary to place the student on the floor...escort [needed], but not all point restraint”. A second report regarding the restraint of a 5th grader states, “after reviewing the hold as a team, we are all in agreement that although the escort was necessary, initiating a basket hold was NOT necessary.” A third report states “I think we are all in agreement that although the two person

escort was necessary, it was NOT necessary to transition him into a two person full prone position.” A fourth report states that the restraint was necessary, but not a prone restraint.

In addition to all of the above evidence, DLC also reviewed an extensive report written by the Social Work Department at Westfield State University. This report was written after an evaluation of the program from September, 2014-May, 2015, as part of a program evaluation learning project for students. The program was overseen by Dr. Jennifer Propp and Dr. Nora Padykula and was conducted to obtain qualitative and quantitative data about TIP. The findings in Westfield State’s report affirmed many of the violations we discovered during our investigation, including improper restraint .⁴

A central reason why this level of violence is of such great concern relates to the nature of the program and the students it serves. This program holds itself out as a special education program designed to educate emotionally disabled children. While illegal restraint and abuse is always improper, this type of illegal restraint of children with emotional disorders is especially egregious. The TIP Handbook states that the program is “guided by the philosophy of Positive-Based Interventions and Supports Model (PBIS)...[which] emphasizes preventive positive approaches for addressing problem behavior instead of emphasizing traditional aversive measures. ...[T]o qualify for placement into the TIP Program, through the IEP process, a student must be identified as having an emotional disability. Examples of emotional disabilities are mood, anxiety, and trauma-related disorders”.⁵ The school has failed to follow its own stated philosophy and has failed to provide safe and effective educational services to meet the needs of this population. **Every student record we reviewed confirms that the child has an emotional disability, many with Post Traumatic Stress Disorder (PTSD).⁶ These children have witnessed extreme incidents of violence and/or have experienced physical or sexual abuse. To put this population in a setting where they are subject to violent and excessive restraints, greatly exacerbates their disabilities and is in direct violation of the stated mission of the program.**

⁴ The report discusses nine areas of concern: Therapeutic vs. Academic vs. Behavioral Management, Safety, Social and Cultural Challenges, Communication, Program Structure, Training, Leadership, Resources, Program Impact.

⁵ Holyoke Public Schools TIP Program Staff Handbook/Resource Guide 2014-2015 p. 3.

⁶ The Mayo Clinic defines Post Traumatic Stress Disorder (PTSD) as a mental health condition that’s triggered by a terrifying event – either experiencing it or witnessing it. Symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event.

“[Our program has] kids that were traumatized sexually and [staff] restrain them in a way where they re-traumatize the kids...the problem is very deep.”

TIP counselor quoted in The Westfield State Report

These systemic practices need to change to protect these children from further harm. The use of excessive force when placing an individual with a disability in bodily restraints, using restraint in violation of Federal and State laws, and engaging in practices that are likely to cause immediate and long term physical harm or psychological harm, all constitute abuse and neglect under the Protection and Advocacy statutes.⁷

B. Failure to report Extended Restraint or Restraint Injury to DESE

It is the responsibility of the school system to set up a safe environment where children with disabilities can obtain an individualized education that meets their needs. Our investigation documented that many students have been injured during improper restraints at TIP and have been subject to extended restraints that were not reported to DESE. The Department of Education has a system set up to monitor restraint injuries and extended restraints, so that it can intervene, when necessary, to protect the safety of children in Massachusetts schools. Under 603 CMR 46.06(5), schools are required to report to DESE when a restraint has resulted in a serious injury to a student or when the restraint has lasted longer than 5 minutes.⁸ As reflected in the PQA Findings, injuries and extended restraints were not reported to DESE. “In the course of its investigation, the Department noted the following additional serious concern with the school’s

⁷ 45 C.F.R. § 1386.19, 42 C.F.R. § 51.2

⁸ When a restraint has resulted in a serious injury to a student or program staff member or when an extended restraint has been administered, the program shall provide a copy of the written report required by 603 CMR 46.06(4) to the Department of Elementary and Secondary Education within five school working days of the administration of the restraint. The program shall also provide the Department with a copy of the record of physical restraints maintained by the program administrator pursuant to 603 CMR 46.06(2) for the thirty day period prior to the date of the reported restraint. The Department shall determine if additional action on the part of the public education program is warranted and, if so, shall notify the public education program of any required actions within thirty calendar days of receipt of the required written report(s).

implementation of restraint requirements. Some restraints were longer than 20 minutes, some reports showed there were significant student injuries and these restraints were not reported to the Department as required by 603 CMR 46.06(5)". The fact that there have been multiple injuries and extended restraints that have not been reported, demonstrate a systemic problem that puts children at risk. This reflects a school that has failed to provide safe interventions to the students in its program. These improper restraints do not comply with Federal and State laws and thus constitute abuse and neglect under the Protection and Advocacy statutes.⁹

C. Improper Seclusion of Students likely to Cause Physical or Psychological Harm

The students in the TIP program have been subject to many practices of seclusion that are likely to cause physical and psychological harm. The most egregious seclusion reported was that on at least three occasions, a teacher put children in a locked closet and turned out the lights. When we interviewed the teacher in question about these incidents, she denied it, stating that another student had locked the door. However, her version is not supported by the record. When discussing this practice with the administration, we were told that the teacher is still employed at the school, but her job responsibilities have changed and she no longer has any direct contact with students. Two staff members reported these incidents to us and expressed their concern about the harm this caused the students. They reported that at least one of the students is having trouble sleeping and is now afraid of the dark. In Liza Hirsch's complaint, she includes this as an example of improper seclusion in the TIP program. In her appendix, she attached two student letters and a parent letter discussing the harm caused by being locked in a closet. The PQA Letter of Finding determined that locking students in a closet is indeed a seclusion restraint in violation of 603 CMR 46.02(5) (b)¹⁰. The Finding states "[t]he District's Report leaves unrefuted the complainant's allegation that the same teacher initiated seclusion restraints, by placing a student in the closet and turning off the light in three separate instances. It is the Department's determination that the incident described constituted a seclusion restraint. Seclusion restraints are prohibited in public programs." During our family interviews, some parents talked about children being locked in a closet and the fact that they had filed with DCF as a result.

⁹ 45 C.F.R. § 1386.19, 42 C.F.R. § 51.2

¹⁰ Seclusion Restraint: Physically confining a student alone in a room or limited space without access to school staff. 603 CMR 46.02(5)(b)

In addition to the above seclusion, our investigation has revealed that the TIP students are secluded generally from the social and educational opportunities provided at the Peck school. TIP students enter and exit the building using separate doors, are subject to daily pat downs and wand searches, and are not allowed to attend field trips or school dances. One TIP teacher expressed a lot of concern about the restrictive nature of the TIP program and stated that staying in this program is harmful to his students. He has worked hard to try and get his students integrated into the general population. Another staff member reported that students “get worse” in this program, both behaviorally and emotionally as a result of this segregation. The segregation of students at TIP is likely to cause psychological harm and demonstrates a failure of the school to provide a safe environment that constitutes abuse and neglect under the Protection and Advocacy statutes.¹¹

D. Improper Neglect for Failing to Provide a Safe Environment

During each visit to the Peck school, DLC staff observed many concerning safety issues in the building. Most notably is the fact that all of the windows in the TIP program are missing screens. While it is important to have fresh air in the classrooms (we only observed one window air conditioner in the program), multiple staff (both administrators and teachers) reported that children climb out of the open windows. For a school that holds itself out as a therapeutic placement for children with emotional disabilities, setting up an environment where children can easily climb out the windows is dangerous. In addition, the overall structure of the building is an octagon. The administration explained during our tour, that the hallways keep turning and therefore you can't see who is ahead or behind you. This makes it very difficult to find children who run out of the classrooms. Overall these safety concerns made us question the decision to place TIP in this environment. In addition, we observed a building in great need of repair. DLC observed and photographed multiple holes in the walls, water damage on the ceiling, missing ceiling panels, and poor conditions throughout the classrooms. We also observed a room that was torn apart, desks upside down with papers and materials all over the place. The administrator could not give us an explanation for the condition of the room. All of these conditions result in a failure of the school to provide a safe environment for these children with disabilities and constitutes abuse and neglect in violation of the Protection and Advocacy statutes.¹²

¹¹ 45 C.F.R. § 1386.19, 42 C.F.R. § 51.2

¹² 45 C.F.R. § 1386.19, 42 C.F.R. § 51.2

E. Improper Neglect for Failing to Carry out Individual Program Plans

Children are placed at TIP because they have emotional disabilities and need special education services to access the curriculum. These are children that need therapeutic services and supports to make effective progress. During our interviews, we heard repeatedly that the staff lacks the training and tools to address behaviors and that they don't have the necessary strategies to handle the children and to de-escalate conflict. We heard multiple reports from parents and staff that children are verbally abused at TIP on a regular basis. This includes screaming at students, publicly shaming them, and threatening them. One teacher stated that “[a] lack of training and tools to address behaviors is hurting students.” In Ms. Hirsch’s letter she describes this negative culture and provides an example of public shaming of a student when a teacher asked the whole class to write down another student’s “bad behavior.” We also heard that the school will routinely call the police to resolve issues when children are in crisis and in need of mental health supports. One teacher stated that he wanted to call the local mental health crisis team but the administration called the police instead. This pattern perpetuates the cycle of children transitioning from a schoolhouse to jailhouse instead of receiving appropriate disability related services. According to data from the Department of Education, “three quarters of students who face disciplinary physical restraint have been classified as students with disabilities. These children walk a well-worn path from the schoolhouse to the jailhouse”¹³. The failure of TIP to provide effective behavioral interventions and then to call the police to intervene, can have a long-standing devastating impact on these children with disabilities.

Many parents reported that IEPs are not being followed and that their children are not receiving an education. One parent went so far as to say that their child is being “warehoused” at TIP. Another parent reported that their child was supposed to have partial inclusion in the mainstream classes and that this was not happening. Parents also reported that their children are sent home for behavioral issues on a regular basis without the rights of suspension. Ms. Hirsch’s letter goes into detail about this practice and PQA found the school in non-compliance for both regularly keeping students in a student support room or sending them home without documenting these practices as suspensions. In addition, DLC heard many complaints that students are doing very little or no academics while they are in their classrooms. During our multiple extended visits of the TIP program, we observed very little academics being performed. We saw children on computers, playing games, eating fast food that the school had purchased, and watching

¹³ Remarks by Attorney General Eric Holder at the Annie E. Casey Foundation’s KIDS COUNT 25th Anniversary Dinner, October 1, 2014.

mainstream movies as a class without any clear academic purpose. Another major issue raised by the staff is that the administration refuses to allow the staff to meet as a whole to collaborate and plan cohesive strategies. The result is that employees feel isolated and unable to work together as a team. All of these are examples of how TIP is failing to carry out the individual program plans of these students with disabilities and therefore failing to provide a safe environment which constitutes abuse and neglect under the Protection and Advocacy statutes.¹⁴

V. CORRECTIVE ACTION TAKEN

During DLC's November, 10, 2015 site visit to TIP, we discussed some corrective actions the school is taking to address the above violations. In addition to DLC's investigation, TIP is being reviewed as part of the receivership process and PQA has ordered TIP to comply with a corrective action plan. TIP reported that the following has been implemented:

- Compliance with the PQA Corrective Action described in the October 1, 2015 PQA closure letter;
- Extensive staff changes, including a new acting principal, and five new teachers;
- Contracting with School Based Services to provide on-site case management, training and interventionist services for the TIP program;
- Collection of restraint, seclusion, and suspension data both internally and by School Based Services; and
- Working with the receiver on other aspects of the Turnaround Plan that includes efforts to improve communication, coordination and oversight.

While DLC recognizes that these changes have been made, we continue to have concerns about the extent of the abuse and neglect we found at the school, especially as it relates to the safety of the children in this program. Unless the receiver can transform this isolated program where abusive and punitive measures are prevalent, then the continued appropriateness of such a program must be questioned and re-assessed. In light of the seriousness and extensiveness of the abuse and neglect found by DLC and other oversight agencies, it is essential that the forward

¹⁴ 45 C.F.R. § 1386.19, 42 C.F.R. § 51.2

progress be carefully monitored. Thus DLC will be shifting to a monitoring phase and are demanding the following:

VI. REQUIRED REMEDIAL PLAN

The District must create a detailed measurable remedial plan and submit this plan to DLC by January 15, 2015, which includes the following elements:

1. TIP will fully eliminate the use of prone restraint in its program.
2. TIP will cease to conduct illegal restraint and seclusion and will comply with all State and Federal laws. All staff will be trained regarding the legal requirements to utilize restraint and seclusion.
3. TIP will fully comply with the DESE reporting requirements regarding extended restraint and restraint injury.
4. TIP will install window screens and make other needed environmental changes to provide students with a safe environment in the school building.
5. TIP will fully implement each TIP student's individualized education plan in the least restrictive environment.
6. TIP will develop a working protocol by which behavior issues are addressed by de-escalating such situations using internal staff or other trained mental health providers, unless there are specific exceptional circumstances that would justify calling external law enforcement officers. All staff will receive training regarding this policy.

VII. MONITORING

DLC is also requesting that the District cooperate and help facilitate DLC's monitoring of this remedial plan for a period of twelve months. After twelve months, DLC will determine if any further action/monitoring is required. The monitoring will include the following:

I. Record Review

On a quarterly basis (January 15, 2015, April 15, 2016, July15, 2016, and October 15, 2016), TIP will provide DLC with the following records:

- A. All restraint/seclusion reports and data collected by TIP staff.
- B. All restraint/seclusion reports and data collected by SBS.
- C. All Restraint Evaluation Team logs.
- D. All records of restraints reported to DESE.
- E. Records of all restraint/seclusion training of TIP staff, including the names of staff trained, subject of the training, hours completed and who conducted the training.
- F. All nursing logs of post restraint physical exams.
- G. Documentation of any improvements made to the building to promote a safe environment.
- H. Reports involving police or crisis intervention including why they were called and action taken as a result.
- I. All logs from the intervention rooms.
- J. Any other internal record or document reflecting corrective action taken involving the violations in this report.

II. On Site Monitoring

Within 30 days of receiving the above quarterly reports, DLC will conduct an on-site visit. These visits will include staff interviews, building tours, and classroom observations.

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