DISABILITYRIGHTSDC

MARCH 2025

YOUTH STILL AT RISK

A SUPPLEMENT TO THE DISABILITY RIGHTS DC'S YOUTH AT RISK REPORT

DISABILITY RIGHTS DC
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DISABILITY RIGHTS DC AT UNIVERSITY LEGAL SERVICES

Since 1996, Disability Rights DC at University Legal Services, Inc. ("Disability Rights DC"), a private, non-profit legal service agency, has been the federally mandated protection and advocacy (P&A) program for individuals with disabilities in the District of Columbia. As such, Disability Rights DC provides legal advocacy to protect the civil rights of District residents with disabilities and investigates allegations of abuse and neglect.

Disability Rights DC staff directly serve hundreds of individual clients annually, with thousands more benefiting from the results of investigations, institutional reform litigation, outreach, education, and group advocacy efforts. Disability Rights DC staff members address client issues relating to, among other things, abuse and neglect, community integration, inclusion in education, accessible housing, financial exploitation, access to health care services, discharge planning, and the improper use of seclusion, restraint, and medication.

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EXECUTIVE SUMMARY

In spring 2024, Disability Rights DC at University Legal Services ("Disability Rights DC") received a complaint of abuse regarding the injury of a youth, Jesse,[1] due to the improper use of restraint techniques by staff members at the District of Columbia's Youth Services Center ("YSC"). Disability Rights DC's investigation included a review of the videotape footage provided by the District's Department of Youth Rehabilitation Services ("DYRS") which showed that YSC staff used unapproved and dangerous techniques while restraining Jesse, *including implementing a dangerous chokehold*.[2] DYRS' own investigation into the spring 2024 incident found that in addition to using a chokehold on Jesse, a staff member used a chokehold on another youth and also dragged the youth across the floor by his clothing and one of his legs.[3]

In the fall of 2024 Disability Rights DC received two additional complaints involving Jesse. Disability Rights DC's investigation into these additional incidents revealed that staff implemented similar abusive and dangerous restraint practices including that staff again implemented chokeholds, a staff member appeared to rapidly punch his closed fist straight down towards Jesse's face or shoulders while Jesse's legs and arms were restrained by three other staff members, multiple staff pinned Jesse to the floor for over eight minutes and several staff pinned Jesse to the floor in *a prone position for over three minutes* while intermittently laying on top of him with their entire body weight.[4]

Jesse sustained injuries and/or required medical attention following the spring and fall incidents. During the spring of 2024 incident, Jesse suffered swelling and bruising to his face and was also reportedly spitting blood after the incident.[5] Jesse reportedly told staff during the second incident that he could not breathe and required treatment for his asthma.[6]

In addition to the investigation findings, Disability Rights DC's routine monitoring at YSC revealed that the facility continues to overuse seclusion practices, in violation of DYRS policy.[7] This practice results in youth being confined alone in their rooms, sometimes for most of the day and evening hours, which can cause significant trauma to the youth in their care.[8]

This is Disability Rights DC's second report in two years detailing the egregious use of force during restraint incidents, as well as disturbing seclusion practices at DYRS facilities.[9] Disability Rights DC's November 2023 report detailed a disturbing series of events at the New Beginnings Youth Development Center, another facility operated by DYRS.[10] In that incident, staff implemented an unauthorized and dangerous restraint of a 16-year-old boy with a mental health disability, significant trauma history, and asthma.[11] Videotape footage showed an encounter eerily reminiscent of the restraint used to subdue—and subsequently kill—George Floyd, in which a large male staff member pinned the youth in a prone position and applied force to his neck.[12] The same staff member kicked and shockingly, bit the youth prior to other staff members physically assisting the male staff member to leave the area.[13] In addition to this disturbing and dangerous restraint, the November 2023 report uncovered systemic violations of District law and DYRS policy restricting the use of seclusion.[14]

DC law and DYRS policy places strict limits on the use of restraint and seclusion. DC law specifically prohibits DYRS staff from using chokeholds and asphyxiating restraints on youth.[15] DYRS policy also specifically prohibits the use of chokeholds, as well as, "any form of excessive interventions… ."[16] DYRS's policy allows for physical intervention only as a last resort, when the youth is an imminent threat, and only after staff attempt alternative interventions.[17] Similarly, staff can only use seclusion, or room confinement, when youth present an imminent threat and "have not responded to less restrictive methods of control or for whom less restrictive measures cannot reasonably be tried… ."[18]

When staff employ unsafe and unauthorized techniques, the youth in their care are at risk of significant trauma, serious injury, and even death. Prone restraints, the use of chokeholds, and placing excessive body weight on an individual during a restraint are widely condemned and can lead to death.[19] According to a local media report, in 2020, a 16-year-old youth in a Michigan youth facility died *less than 10 minutes* after seven staff members restrained him by lying on his legs, chest, and neck.[20] A local media outlet reported that in 2021, a 21-year-old student with autism and schizophrenia in Texas was killed after being restrained in a prone position for attempting to leave the classroom.[21] A local Virgina media organization reported that in June 2024, a 34-year-old man died of "positional

and mechanical asphyxia due to restraint of neck and torso compressions," after five officers restrained him during a mental health crisis.[22]

In addition to the potential physical danger, DYRS's own policy recognizes the trauma of restraint and seclusion, noting that "the use of physical intervention against youth can cause serious psychological, physical and developmental harm" and notes that staff must comply with DYRS policy "in order to limit injuries to youth and staff, foster positive youth-staff relationships and comply with national standards and best practices."[23] DYRS policy recognizes that the use of mechanical restraints, which includes handcuffs, can be dangerous to all involved as well, and "can harm youth-staff relationships which ultimately impacts facility safety and security."[24] DYRS has historically acknowledged the harms of seclusion practices, stating that "isolation and solitary confinement of youth can cause serious psychological, physical, and developmental harm to residents, as well as deleterious effects on youth-staff relationships which ultimately impacts facility safety and security."[25] DYRS' updated room confinement policy inexplicably eliminated this wording.[26]

Research has confirmed that children who are subjected to seclusion and restraint suffer from a reduced ability to learn, an increased chance of resisting teachers and health care providers due to a breakdown in trust, and the loss of a sense of safety.[27] Research shows that both seclusion and restraint "can actually fuel violence" creating a cycle in which the use of seclusion and restraint reinforces aggressive behaviors in youth who are secluded or restrained.[28]

As Disability Rights DC emphasized in our November 2023 report, DYRS must make significant changes to its seclusion and restraint practices to ensure that the youth in their care are safe and are not traumatized.[29] They must effectively train and support staff, and when necessary, hold staff accountable for their improper use of these interventions. Disability Rights DC reiterates the need for the implementation of the critical recommendations proposed in the November 2023 report, including that DYRS should (1) ban the use of prone restraints, (2) significantly modify its staffing and training practices, (3) revise internal policies to be more comprehensive, and (4) increase the District's oversight measures to ensure its juvenile facilities are safe and actually promote rehabilitation and healing. DYRS administration must ensure that all staff adhere to all DYRS policies that restrict the use of restraint and seclusion/room confinement. Disability

Rights DC also recommends DYRS adhere to current standards of practice and incorporate a trauma informed approach in their care practices.[30]

DC LAW AND DYRS POLICY REGARDING THE USE OF RESTRAINTS

DC law explicitly prohibits law enforcement officers, including DYRS employees, from using "asphyxiating restraints" and "neck restraints.[31] "Asphyxiating restraints" include the use of a DYRS employee's body part "against a person with the purpose, intent, or effect of controlling or restricting the person's airway or severely restricting the person's breathing."[32] "Neck restraints" include the use of any body part or object by a law enforcement officer "to apply pressure against a person's neck … with the purpose, intent, or effect of controlling or restricting the person's airway, blood flow, or breathing."[33] DC law also places responsibility on observing staff members to provide immediate medical aid when prohibited techniques have been used.[34]

Moreover, DYRS' physical intervention policy explicitly prohibits certain techniques including, hitting youth with a closed fist, throwing youth into a wall or floor, pulling a youth's hair, kicking or striking youth, chokeholds, or "any other unapproved form of physical intervention or intervention which staff have not received training to apply."[35] Staff are also forbidden to use excessive physical intervention such as intentional physical abuse, punishment, coercion, or retaliation.[36] Moreover, DYRS policy states that "[i]f use of physical intervention is necessary, staff shall only use approved *defensive* physical intervention techniques…and only use the amount of force necessary to ensure the safety of youth and others or prevent escape."[37]

DYRS STAFF MEMBERS PLACED YOUTH IN DANGER IN SPRING 2024

As described below, Disability Rights DC's investigation of the spring 2024 incident found that YSC staff violated DC law and DYRS policy and/or used dangerous techniques with Jesse, including when staff members (1) failed to use proper and

approved physical restraint technique on multiple occasions, including multiple chokeholds; (2) dragged Jesse into his room while he was still in a chokehold; (3) placed him in a prone position while applying handcuffs, and (4) failed to use meaningful de-escalation strategies prior to initiating restraints.[38]

DYRS's investigation of the spring 2024 incident also confirmed serious staff violations of DYRS policy, including staff members' use of dangerous and prohibited restraint techniques.[39] DYRS' own internal investigation report concluded that a supervisory staff member used "excessive force against [Jesse] by placing him in a chokehold position during the incident," and that "[a supervisory staff member] used physical maneuvers that were not approved Safe Crisis Management restraints, violating the Use of Physical Intervention Policy."[40]

Below is a detailed summary of Disability Rights DC's analysis of the videotape footage of the staff members interaction with Jesse that was provided to Disability Rights DC by DYRS. *Disability Rights DC's analysis includes tracings of screenshots of the videotape footage to protect privacy.*

ANALYSIS OF VIDEOTAPE FOOTAGE

Videotape footage of the spring 2024 incident begins with seven youth in the common space of the unit along with three staff members.[41] Two of the youth are playing cards, while the other youth appear to be sitting and talking with one another or standing and speaking with staff members.[42] Two male staff members leave the unit, which leaves only one female staff member with seven youth. [43] About a minute later, the youth begin to move tables and chairs in front of the exit and room doors and pour water onto the floor.[44] About five minutes later, one additional female staff member and two male staff members enter the unit.[45]

Jesse remains in the common space, seated in a chair against the wall, with his arms folded.[46] Three staff members, approach Jesse and almost immediately place their hands on Jesse's shoulders and folded arms.[47] The two male staff members stand on either side of him while the third staff member stands in front of him.[48]

Staff members hold Jesse's arms as he sits calmly in a chair.

The staff members appear to speak with Jesse for less than one minute as they intermittently hold his arms and shoulders.[49] Although Jesse appears to stay calmly seated in the chair and does not appear to exhibit any physically aggressive behavior, both male staff members suddenly initiate a physical restraint by physically pulling Jesse to his feet. [50]

Staff members initiate a physical hold and force Jesse out of the chair though he is not exhibiting aggressive behavior.

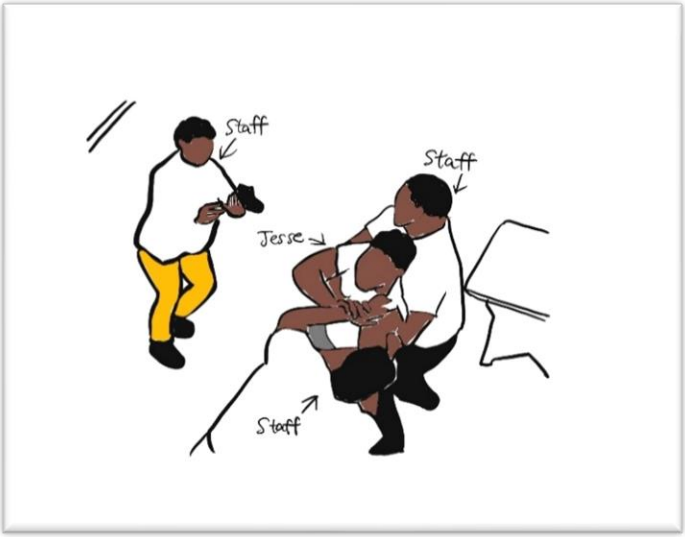
Jesse struggles to get free from the physical restraint as the two staff members continue to grab his arms and maintain the physical hold with difficulty.[51] The two staff members then push Jesse against the wall.[52] While Jesse struggles to be free of their grasp, Jesse falls on the floor hitting the chair, and lands in a prone position.[53] A male staff member falls on top of him.[54] While Jesse is on the floor, one staff member attempts to hold Jesse's legs, one male staff member appears to be applying pressure to Jesse's upper body, and one staff member appears to be kneeling on the side of Jesse's torso.[55]

Jesse is on the floor while three staff members are on top of him. One staff member attempts to hold Jesse's legs, one male staff member appears to be applying pressure to Jesse's upper body, and one staff member appears to be kneeling on the side of Jesse's torso.

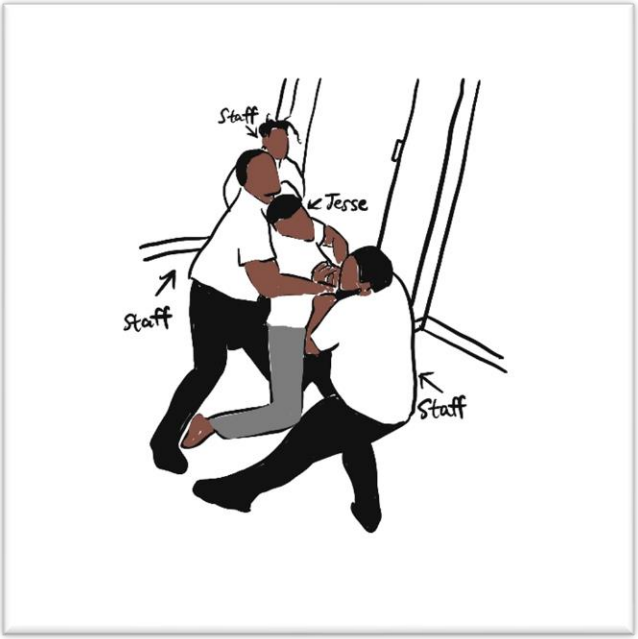
Jesse then maneuvers into a kneeling position.[56]

Jesse is kneeling on the floor while staff members appear to be holding him down.

While in the corner, the three staff members encircle him before allowing Jesse enough room to stand up.[57] Staff members appear to speak with Jesse as they surround him.[58] Jesse then attempts to walk away from the three staff members.[59] Even though Jesse appears to be attempting to get some physical space from staff members and does not exhibit any overt physical aggression, staff members continue to surround him.[60] One male staff member appears to be talking to Jesse in an emotionally heightened manner a few inches from Jesse's face.[61] While he is still standing, both male staff members physically restrain Jesse's arms.[62] When Jesse tries to break free, one large male staff member picks Jesse up off of the floor from behind in a tight bear hug position, with his hands clasped around Jesse's midsection.[63] The struggle continues, with Jesse attempting to break free.[64] When one staff member loses his grip on Jesse, the staff member appears to swing his arm towards Jesse and also grabs at the collar of Jesse's shirt.[65]



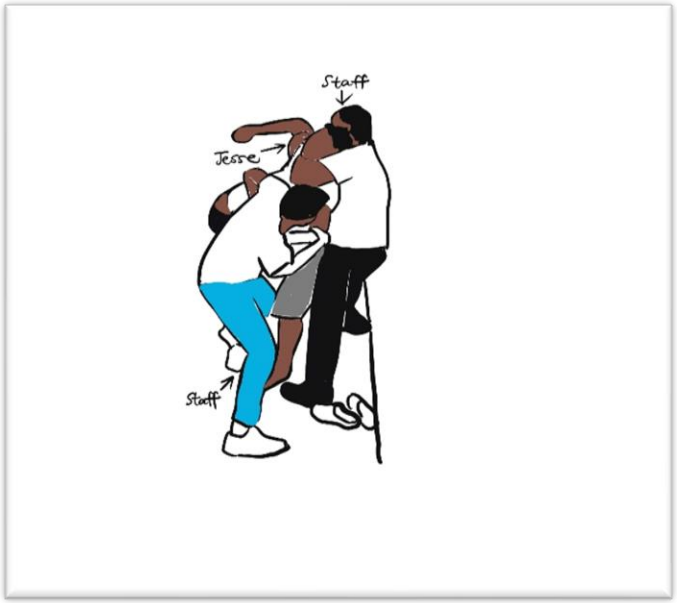
A staff member has his arms around Jesse's torso while holding him. Another staff member is attempting to grab Jesse's arms.



A staff member continues to keep pressure around Jesse's torso while another staff member continues to grab at Jesse's arms.

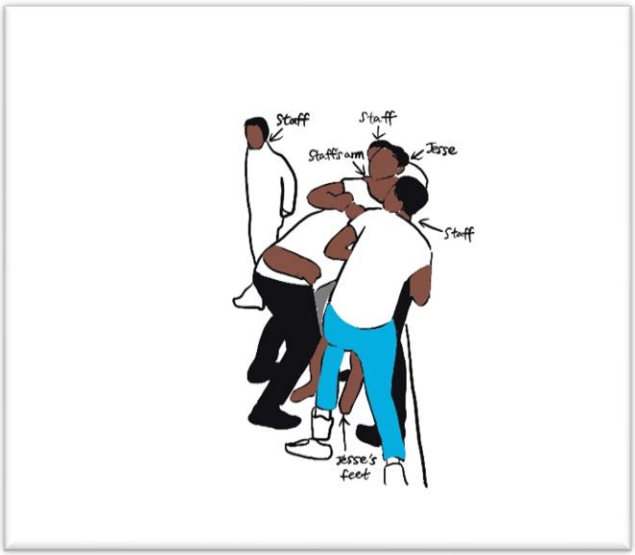
While one staff member maintains a bearhug type grip, the two male staff members forcibly pull Jesse into his room.[66] Five staff members initially enter the room, then four staff members leave the room.[67] Inexplicably, one female staff member remains in the room with Jesse; the door to this room is closed *for 36 minutes*.[68] Throughout the 36 minutes, staff members periodically stand outside of Jesse's door and appear to speak through the window on Jesse's room door.[69]

Approximately, 36 minutes after Jesse has been alone in the room with the female staff member, three male staff members gather outside Jesse's door.[70] When a staff member opens Jesse's door, he tries to run out of his room.[71] One large male staff member grabs Jesse around his left shoulder and under his right arm while another male staff member attempts to grab his legs.[72] *The large male staff member then places his forearm around Jesse's neck and places him in a chokehold – a very dangerous and prohibited practice.* [73]



A male staff member appears to have his arm around Jesse's neck in a chokehold.

The other male staff member then places Jesse in even more danger when he appears to lift Jesse's legs off of the floor while the other staff member still has Jesse in a chokehold.[74] The third male staff member then grabs Jesse's left arm.[75]



A male staff member has his arms around Jesse's neck while another male staff member appears to lift Jesse off of the floor.

Staff proceed to drag Jesse into his room while still in the chokehold.[76] *The male staff member appears to have his arm around Jesse's neck for at least ten seconds prior to entering the room.*[77]

The staff members drag Jesse into his room.

Four staff members enter the room.[78] Although no videotape footage is available from inside Jesse's room, according to the facility documentation, staff members then place Jesse in handcuffs.[79] The DYRS investigation of the incident revealed that when interviewed, two staff members described that they placed Jesse in a prone position in his room while applying handcuffs, another very dangerous restraint technique that can cause injury and even death. [80]

JESSE SUFFERED SERIOUS INJURIES

Jesse reported that during the incident he was unconscious after being placed in a chokehold and that he hit his head on the toilet prior to being placed in handcuffs.[81] According to the DYRS investigation report of the incident, Jesse stated that during the chokehold he became unconscious and that he "woke up

under the toilet" in his room and "that a staff person had his knee and hands on [his] head."[82]

After the incident, Jesse's face and eye were bruised and swollen.[83] When asked how he sustained his eye injury, Jesse replied that the right side of his face was on the ground, and his face "was hurting real bad."[84] He also reported that his wrists hurt and that a staff member made derogatory comments towards him.[85] During interviews for the DYRS investigation, staff members reported that while in his room, staff members and Jesse all fell in such a way that Jesse landed on the ground face down near the toilet.[86]

The DYRS investigation report also repeatedly documented that after Jesse was placed in the chokehold, staff members saw that Jesse was spitting blood,[87] and multiple staff members reported that while he was in the restraints, Jesse spit out blood from his mouth.[88] One staff member reported seeing blood under Jesse's right eye as well.[89] When a nurse assessed Jesse after the restraint, the nurse noted the handcuffs were too tight for Jesse without the standard two-finger space between the limb and apparatus.[90] Notably, neither the medical records or incident reports include mention of Jesse spitting blood.

STAFF MEMBERS USED DANGEROUS TECHNIQUES ON OTHER YOUTH DURING SPRING INCIDENT

As previously noted, DYRS's own investigation found that staff violated multiple DYRS policies when attempting to restrain Jesse. The investigation report also made extremely disturbing findings involving other youth during the incident, which included: (1) A staff member grabbed a youth by the shirt with both hands and then proceeded to *place his right arm around the youth's neck in a chokehold;* (2) A staff member "attempt[ed] to wrap both arms around [a youth] under his arms" and the youth subsequently fell to the floor; and (3) A staff member grabbed a youth by his shirt with both hands and forcefully dragged him across the floor.[91] The DYRS investigation concluded that during the incident, staff members used excessive force and "physical maneuvers that were not approved Safe Crisis Management restraints, violating the Use of Physical Intervention Policy."[92]

STAFF MEMBERS FAILED TO EMPLOY MEANINGFUL DE-ESCALATION TECHNIQUES

In addition to the important restrictions regarding physical intervention already discussed, DYRS's Physical Intervention Policy states that staff may use physical intervention against a youth "*only after alternative verbal interventions have been exhausted or are impossible.*"[93] DYRS' mechanical restraint reiterates these restrictions: "Handcuffs may only be used after all less restrictive de-escalation strategies have been exhausted and when it is clear that less restrictive methods of control are not feasible. These strategies include verbal de-escalation techniques, approved physical intervention techniques and interventions by behavioral health staff."[94]

Adequate and meaningful de-escalation techniques are critical to avoid dangerous and traumatic situations. DYRS policy provides specific techniques staff should attempt prior to resorting to room confinement, entitled "Preventive Interventions" which provide guidance for de-escalation techniques. The policy includes that staff should: (1) intervene immediately to avoid escalation; (2) provide youth with clear direction and specific verbal instructions; (3) encourage youth to engage in conversations by talking with the youth about making good decisions; (4) discuss alternative ways to resolve the issue, provide an empathy or praise statement; (5) use the physical redirect technique to guide the youth in a non-aggressive, non-threatening manner; (6) utilize interventions consistent with the behavior modification program de-escalation strategies; and/or (7) request assistance from any member of the youth's core support team.[95]

DYRS did not provide Disability Rights DC with evidence that staff meaningfully attempted these important steps or other de-escalation strategies.[96] To the contrary, videotape footage shows that during the spring 2024 incident, several staff members made physical contact shortly after approaching Jesse, which escalated the situation, instead of allowing him to remain calmly sitting in the chair, where he was not displaying any aggressive behavior.[97]

STAFF FAILED TO ADEQUATELY AND ACCURATELY DOCUMENT THE SPRING INCIDENT

The DYRS Unusual Incident Reporting Policy requires staff to report any "reportable incident" or any incident that occurs "which may impact the integrity and public confidence in DYRS operations."[98] Nevertheless, the DYRS investigation found that four staff members, including two supervisory staff members, did not complete an incident report in violation of the Unusual Incident Reporting Policy.[99] Notably, despite six staff members being involved or witnessing the incident, when asked whether Jesse was placed in a chokehold, no staff members reported seeing the staff member place Jesse in a chokehold position even though it can be clearly seen on the videotape footage.[100]

Moreover, DYRS policy on the use of physical intervention and the use of mechanical restraints requires that staff conduct a debriefing between the youth and staff following the incident, which is specifically intended to include "what might have prevented the need for force and alternative ways of handling the situation."[101] However, there is no indication in the records provided by DYRS that a debriefing occurred.

DANGEROUS RESTRAINT OF JESSE IN FIRST OF TWO FALL 2024 INCIDENTS

Disability Rights DC investigated two additional incidents involving Jesse in the fall of 2024. During the first of the two fall 2024 incidents, and disturbingly similar to the spring 2024 incident, staff used strictly prohibited and dangerous interventions, including when (1) A staff member put Jesse in a chokehold (2) a staff member appeared to rapidly punch his closed fist straight down towards Jesse's face or shoulders while Jesse's legs and arms were restrained by three other staff members, and (3) multiple staff members restrained Jesse on the floor for more than eight minutes while intermittently placing their entire body weight on him.[102]

Videotape footage reveals that on a fall afternoon, Jesse and another youth engaged in physical altercation while in the common area of their unit.[103] Staff

members were initially unable to separate the youth. Then one staff member physically restrained one youth, and two other staff members attempted to physically restrain Jesse by holding his arms. During the restraint, the staff member and Jesse backed into a table as one staff member held Jesse's right arm and the other placed their arm around his neck, putting Jesse into a chokehold.[104] As one staff member held Jesse's arm and another had their arm around his neck, Jesse bent over and fell to the floor.[105] The staff member holding him in the chokehold then appeared to fall on top of Jesse.[106] After the fall, Jesse continued to resist, attempted to break out of their grasps, and tried to get to his feet.[107]

Four additional staff members entered the unit and immediately surrounded Jesse.[108] Jesse got onto his knees and while the six staff members attempted to restrain him, one staff member again placed his arm around Jesse's neck, pushed him forward and flipped him onto his back.[109] While on the ground, one large male staff member laid his body directly on top of Jesse.[110]

While the four staff members attempted to restrain him on the ground, one staff member appeared to punch his closed fist straight down near Jesse's face or shoulders while Jesse's legs and arms were restrained by three other staff members.[111] The staff member then stood up and was immediately escorted by other staff members to the unit door.[112] Another male staff member then grabbed Jesse's legs, lifted his legs and lower back off the ground then twisted Jesse's body.[113] This staff member subsequently appeared to have his entire weight on Jesse's legs.[114] Yet another staff member entered and kneeled above Jesse's head.[115] Jesse continued to resist as seven staff members intermittently maintained the restraint for five minutes. Jesse was pinned on the ground for eight minutes and 25 seconds.[116]

Finally, the staff allowed Jesse to sit up.[117] Jesse was able to get to his feet and then made another attempt to avoid the staff members' grasps.[118] In response, staff pinned him onto a nearby table.[119] At this point, a total of twelve staff were on the unit, as several of them attempted to restrain him on the table.[120] Jesse struggled and was able to kneel on top of the table.[121] A staff member then pulled Jesse off of the table by the nape of his shirt.[122] Once again, staff members attempted to restrain Jesse, and appeared to have him pinned to the table.[123] The twelve staff members then collectively pushed and pulled Jesse into his room, as three of the staff members appeared to have Jesse's arms restrained.[124] All but

three staff members exited that room before staff closed the room door. At this point, the videotape footage provided by DYRS to Disability Rights DC ends.[125] According to DYRS records, after the incident, Jesse was "hunched over on the bed reporting chest tightness and shortness of breath" and that he required use of his inhaler.[126]

In addition to using dangerous techniques during the restraint as described in detail regarding the spring 2024 incident, staff again failed to follow DYRS policy designed to prevent the need for such dangerous physical intervention and require staff to attempt other, less restrictive strategies prior to resorting to physical restraint.[127] Once staff were able to separate the youth and clear the dayroom, they could have, for example, given Jesse some physical space and allowed him to have an opportunity to calm down. The "show of force" of twelve adult staff surrounding a 16-year-old youth seemed only to initiate a "fight or flight" response in Jesse – a response that could be expected of a youth who had experienced significant trauma. Moreover, this excessive physical intervention placed both Jesse and the staff at unnecessary risk and again caused Jesse to need medical attention.

DYRS INTERNAL INVESTIGATION OF THE INCIDENT

The DYRS own internal investigation into the fall 2024 incident noted that three staff, including two supervisors reported that Jesse voiced concern about his inability to breathe during the restraint.[128] Two additional staff members reported that Jesse complained that someone was on his neck.[129] Yet a supervisor involved who was present for the incident reported that he had no concerns about how staff members conducted the restraint.[130]

It is critical that DYRS investigations accurately analyze and scrutinize videotape footage of serious incidents and make meaningful recommendations to ensure that such incidents do not occur in the future. Despite clear evidence on the videotape as described above that staff engaged in a prolonged and dangerous restraint of Jesse, the investigation did not find specific staff policy violations. DYRS should have cited the many dangerous aspects of a restraint that escalated out of control. Moreover, staff again failed to adequately or accurately report the

incident.[131] DYRS' own investigation failed to provide recommendations to address this dangerous conduct or describe follow-up steps to ensure recommendations are implemented.

DANGEROUS RESTRAINT OF JESSE IN A SECOND FALL 2024 INCIDENT

Disability Rights DC investigated yet another incident involving Jesse in the fall of 2024. As in the other two incidents, staff used prohibited and/or dangerous techniques to restrain Jesse when they: (1) placed him in a prone restraint for over three minutes, and (2) appeared to have placed their entire body weight on Jesse while they pinned him against the wall face first and while he was restrained on the floor in the prone position.[132] YSC staff also violated their policies by not following their incident reporting procedures.[133]

Video footage begins with Jesse and nine other youth and three staff members in the common area of their unit.[134] Jesse ripped up a sandwich into small pieces and dropped the pieces onto the floor.[135] Jesse then stood with his back against the wall with his hands in his pockets.[136] It appeared that the staff members instructed the youth to stand in front their room doors as most of the youth moved simultaneously from the common area towards individual room doors.[137] One staff member appeared to gesture to the sandwich on the ground and then to Jesse.[138] Three additional staff entered the unit.[139] Another staff member then approached Jesse and appeared to speak to him while Jesse continued to lean against the wall with his hands in his pockets.[140]

Over about the next two minutes, two additional staff members entered the unit, and seven staff members gathered around Jesse.[141] The three staff members closest to Jesse appeared to speak to him for a little over two minutes.[142] While Jesse was still standing calmly against the wall, a male staff member gestured for two of the staff members closest to Jesse to move, and two male staff members then grabbed Jesse's arms.[143] As the staff members grabbed his arms, Jesse swung out at a staff member.[144] Six staff members surrounded Jesse and attempted to pin Jesse into the corner of the room.[145] As staff members struggled for control, one staff member appears to have pinned Jesse's arm above his head against the wall. [146]

Staff continued to pin Jesse in the corner for almost five minutes.[147] Additional staff entered the unit.[148] During the five minutes, several staff members maintained a stance indicating much, if not all, of their weight was pinning Jesse into the wall.[149] Two staff members pinned Jesse's shoulders and arms against the wall as staff members moved Jesse down the length of the wall.[150] A third staff member applied pressure to the front of Jesse's body.[151] One staff member appeared to repeatedly lean into Jesse while holding his arm, which pushed Jesse further into the wall.[152] Five other staff members watched the incident in close proximity.[153] Jesse then slid down the wall to a seated position with his arms still restrained.[154]

Staff members appeared to speak with Jesse as he remained restrained and seated on the ground for several minutes.[155] Two other staff members entered the unit and walked over to Jesse.[156] One of the staff members reached around Jesse's shoulder and torso and forced him to his feet.[157] Jesse resisted, trying to break free from the staff members.[158]

As a staff member tried to maintain his hold, both Jesse and the staff member fell on top of the other staff member who was restraining Jesse's other arm.[159] During the ensuing struggle, staff members put Jesse on his stomach, in a prone position on the floor, with one of his arms behind his back.[160] While Jesse was still in a prone position, one staff member lay directly on top of him, while seven others intermittently restrained Jesse's arms and legs.[161] The staff member lying on top of Jesse sat up and placed his knee next to Jesse's thigh, while he periodically moved it to apply pressure directly onto Jesse's lower body.[162] Jesse was held in the prone position on the ground for *over three minutes* with staff members holding his limbs and and/or placing their entire body weight on top of him.[163]

The staff members then picked Jesse up with his arms behind his back.[164] Staff members held Jesse under his shoulder and his arms behind his back, as they forced Jesse's face forward into the wall.[165] Three staff members then held Jesse by his arms and shoulders, and seven staff members walked him backwards towards his room.[166] Three staff members entered into Jesse's room with him, while six other staff members stood outside the room.[167] Staff members remained inside and outside of Jesse's room with the door open for twenty minutes before staff members closed his room door.[168]

As discussed throughout this report, a prone position restraint or any restraint that involves placing a staff member's entire body weight on a youth is very dangerous and cause serious injury or death.[169] As was the case in the other two

incidents, the videotape footage does not provide evidence that staff attempted or employed less restrictive techniques in any meaningful manner as required by policy.[170] After only two minutes of verbal interaction, and when Jesse was calmly standing against a wall and not posing a danger, staff employed a physical restraint, which also violated the policy requirement that staff may not employ a physical restraint unless a youth poses an imminent threat.[171]

Again, staffs' actions appear to have triggered a "fight or flight" reaction in Jesse, which led to a dangerous restraint at a time when no one was at risk of imminent harm or escape. All three restraint incidents involved staff attempting to restrain Jesse multiple times using multiple dangerous techniques. Jesse could have easily been more seriously injured or even killed.[172] Because physically restraining youth can be very dangerous, DYRS policy emphasizes that physical restraint should be a last resort.[173] *Staff must employ meaningful alternative strategies, some of which are outlined in DYRS policy, prior to rushing at a youth and immediately physically restraining them, as they repeatedly did with Jesse.*[174] If restraint is absolutely necessary, DYRS must ensure that staff are adhering to all policy requirements and that they employ only safe, approved restraint techniques.

YSC CONTINUES TO RELY ON PROHIBITED SECLUSION PRACTICES

As the federally designated Protection & Advocacy agency for the District of Columbia, Disability Rights DC conducts regular monitoring and outreach to DYRS facilities.[175] During these visits, and as described in the 2023 Youth At Risk report, Disability Rights DC continues to observe troubling room confinement practices.

Both DC law and DYRS policy place strict limits on the use of room confinement at DYRS facilities.[176] DC law requires that juvenile facilities must have adequate justification to confine a youth to their room and cannot use room confinement "for the purposes of discipline, punishment, administrative convenience, retaliation, or staffing shortages."[177] DYRS policy also places restrictions on the use of seclusion, including that staff only use seclusion when a youth presents an imminent threat and has "not responded to less restrictive methods of control or for whom less restrictive measures cannot reasonably be tried…"[178] Moreover, a youth must be released from room confinement when they no longer present an

imminent threat, and initially, superintendents can only approve seclusion for one hour maximum.[179] If at the conclusion of one hour, a youth continues to demonstrate the need for confinement, the Superintendent may authorize one (1) hour increments of confinement *up to four* (4) hours.[180] If confinement is required beyond four (4) hours, authorization must be obtained from the Chief of Secure Programs.[181]

Disability Rights DC highlighted this practice in our 2023 report in which we described that our monitoring and investigations, along with the work of juvenile justice advocates in the District, uncovered systemic violations of District law and DYRS policy restricting the use of seclusion, including confining youth in their rooms for 23 hours per day. Disability Rights DC also noted the regular practice of only allowing one youth out of their rooms at a time and youth and school staff having to conduct school instruction through the window of their door.[182]

The use of excessive seclusion practices on vulnerable youth, especially children with mental health disabilities, carries a high risk of traumatization and re-traumatization.[183] As previously noted, DYRS policy has historically acknowledged the potential harms of secluding youth, stating that "isolation and solitary confinement of youth can cause serious psychological, physical, and developmental harm to residents, as well as deleterious effects on youth-staff relationships which ultimately impacts facility safety and security."[184]

During multiple monitoring visits in 2024, Disability Rights DC observed that only one youth was out in the common area of one of the girls' units, while all of the other youth on the unit were confined to their rooms.[185] Disability Rights DC was regularly told by staff members that each youth would be given only about an hour out their rooms during the afternoon and evening hours, and would otherwise be confined to their rooms.[186] Thus, according to staff, the youth were alone in their rooms for most of the afternoon and evening hours, again violating DC law and DYRS policy.[187] As already stated in the 2023 report, DYRS must ensure that staff adhere to DYRS policy and must not subject youth to excessive seclusion.

CONCLUSION

Jesse and other youth have repeatedly suffered at the hands of DYRS staff who failed to follow legal and policy requirements when they implemented multiple dangerous restraint techniques. This practice must end now before other youth are seriously injured or even killed. While DYRS conducted its own investigations into the incidents described, they must ensure consistent and comprehensive investigations that result in meaningful change to ensure that staff do not employ unacceptable techniques again. Their own investigations must result in recommendations that require change, and the agency must follow-up to ensure the changes actual take place. DYRS must ensure that all youth entrusted to them are safe. Further, DYRS must also ensure that staff adhere to DYRS room confinement and seclusion policies designed to prevent isolation and psychological trauma. The current practices are dangerous for both the youth and the staff – both suffering from physical and mental harm.

DYRS's mission statement is to "give court-involved youth the opportunity to become more productive citizens by building on the strengths of youths and their families in the least restrictive, most homelike environment consistent with public safety."[188] Subjecting youth to dangerous restraints and lengthy seclusions is a far cry from a homelike environment.

RECOMMENDATIONS

DYRS must make immediate changes to meet their responsibilities under DC Law and their own policies to keep the youth in their custody safe and free from abuse. Disability Rights DC maintains the recommendations presented in the 2023 Youth at Risk Report and further recommends the following:

1. Staff Training/Trauma Informed Care

DYRS must ensure that all staff adhere to DC law and DYRS policy when implementing restraint and seclusion of youth. DYRS must live up to its policy mandate that "Staff shall receive regular training in conflict management, de-

escalation of confrontations, crisis intervention, management of assaultive behavior, and the facility's continuum of methods of control."[189] DYRS should be transparent about the content and regularity of these trainings.

DYRS should contract with trauma-informed care experts so that they can fully incorporate these treatment approaches into the care of all youth in DYRS facilities.[190] DYRS must ensure that changes to treatment practices are meaningful and sustained.

2. Policy Changes

Ban on Prone Position Restraints

Disability Rights DC urges DYRS to explicitly ban prone position restraints, which are banned in Saint Elizabeths Hospital and in D.C. Public Schools.[191] As discussed in this report, prone restraints can be very dangerous due to the impact on a person's breathing and can result in death.[192] In addition, Disability Rights DC recommends that DYRS prohibit staff from placing the majority of or their entire body weight on or into youth during a restraint, as this too can lead to injury or death.[193]

Room Confinement

Disability Rights DC recommends that DYRS and YSC administration ensure that staff adhere to all legal and policy requirements when confining youth to their rooms. DYRS should amend the room confinement policy so that it is clear and precise about when and under what circumstances staff are permitted to lock youth in their rooms.

Disability Rights DC recommends adding the following language that was deleted from the previous DYRS room confinement policy to the current room confinement policy: "isolation and solitary confinement of youth can cause serious psychological, physical, and developmental harm to residents, as well as deleterious effects on youth-staff relationships which ultimately impacts facility safety and security."[194] In addition, Disability Rights DC recommends that DYRS remove the section of the policy that allows for room confinement for up to 72 hours.[195] Secluding a youth to their room for three days in a DYRS facility should never be allowed.

Individualized Plans

DC Code describes developing an individualized plan for youth "to improve the juvenile's behavior, created in consultation with the juvenile, mental health or health staff, and the juvenile's family members that identifies the causes and purposes of the negative behavior as well as concrete goals that the juvenile understands and that he or she can work toward to be removed from special programming."[196] Disability Rights DC recommends a trauma informed care approach in the development of individualized plans developed with the input of a trauma-informed care expert, training on how to implement such a policy, and follow-up to ensure it is being followed.

3. Increase Oversight and Investigation Quality

DYRS must increase its oversight in all DYRS facilities. DYRS staff should review *every incident of restraint* at least until facility staff consistently adhere to all DC law and DYRS policies during the restraint. DYRS must increase its internal monitoring and oversight for quality and consistency of all DYRS investigations, and based on this monitoring, train and retrain staff accordingly.

While DYRS tracks and publishes limited critical incident and assault data, Disability Rights DC recommends that DYRS track all restraints across their facilities to ensure that staff follow all legal and policy requirements, to monitor for patterns of staff failing to comply with such requirements, and to identify opportunities for preventative interventions. Additionally, DYRS should develop a policy to track and trend how much time and under what circumstances youth are forced into room confinement.

4. Meet with Stakeholders

Disability Rights DC recommends that DYRS meet regularly with youth advocates and stakeholders, including Disability Rights DC, to address ongoing concerns. Disability Rights DC welcomes the opportunity to collaborate with DYRS on implementing these recommendations.

Disability Rights DC would like to acknowledge Caitlin Holbrook and Chloe Zu for their significant assistance with this report.

[1] The name of the youth whose alleged abuse and neglect is the subject of this investigation has been changed to protect his anonymity. "Jesse" is used as a pseudonym.
[2] *See* page 14.
[3] OFF. INTERNAL INTEGRITY (OII), Investigative Report: Youth Services Center 15, 16, 17, 18 (Spring 2024) [hereinafter: OII Investigative Report (Spring 2024)].
[4] *See* Analysis of Videotape Footage at page 18-23.
[5] DEP'T YOUTH REHAB. SERVS., Youth Serv. Center (YSC) Medical Records for Jesse 1719 [hereinafter: YSC Medical Records (2024)]; OII Investigative Report (Spring 2024) at 9, 11-12.
[6] OII Investigative Report (Fall 2024) at 11; *see also* YSC Incident Assessment, Medical Records (Fall 2024) at 9, 11.
[7] DEP'T YOUTH REHAB. SERVS., POL'Y & PROCEDURE MANUAL Room Confinement. (May 3, 2024) [hereinafter: DYRS PPM: Room Confinement].
[8] *See* pages 23-24.
[9] Disability Rights DC, *Youth at Risk: Dangerous Restraints and Excessive Seclusion at DYRS Facilities* (Nov.2023).
[10] *Id.*
[11] *Id.* at 2.
[12] *Id.*
[13] *Id.*
[14] *Id.* at 17-18.
[15] D.C. Code § 5-125.03
[16] *Id.* at § VI.B.
[17] DEP'T YOUTH REHAB. SERVS., POL'Y & PROCEDURE MANUAL Use of Physical Intervention § VI.A. (Mar. 13, 2019) [hereinafter: DYRS PPM: Use of Physical Intervention].
[18] DYRS PPM: Room Confinement § V.B. at 2.
[19] *See* Shaila Dewan, *Subduing Suspects Face Down Isn't Fatal, Research Has Said. Now the Research Is on Trial*., NEW YORK TIMES (Oct. 2, 2021), https://www.nytimes.com/2021/10/02/us/police-restraints-research-george-floyd.html; https://ocfs.ny.gov/programs/youth/detention/directives/Ending-Prone-Restraints.pdf.
[20] Following the tragic death, Michigan banned prone restraints in child caring institutions. Michigan Department of Health and Human Services, Prohibition of Prone Restraint; Procedures Involving Other Restraints in Child Caring Institutions Emergency Rules, (July 16, 2020), https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder4/Folder15/Folder3/Folder115/Folder2/Folder215/Folder1/Folder315/2020-208_HS_-_ER_-_Final_-_Prohibition_Of_Prone_Restraint_Procedures_Involving_Other_Restr.pdf?rev=f2f142724ce140f28626d608ae9f99ab; Seven staff members at a youth facility killed Cornelius Frederick, 16-years-

old, when they restrained him in a prone position after he threw a sandwich. Frederick screamed, "I can't breathe," throughout the restraint. Staff waited to start CPR after releasing Frederick from the restraint. The restraint suffocated him, causing brain damage resulting in his death. *Attorney Releases Footage of Teen that Died in Kalamazoo Youth Facility*. Crime and Public Safety. Fox 2 Detroit (July 7, 2020), https://www.fox2detroit.com/news/attorney-releases-footage-of-teen-that-died-in-kalamazoo-youth-facility.

[21] Silas Allen, *Fort Worth Teachers Used Illegal Restraint before Student's Death*, Police Report Shows. Education. Fort Worth Star-Telegram (Nov. 10, 2022), https://www.star-telegram.com/news/local/education/article268519762.html.

[22] Jane Harper, *3 Former Virginia Beach Sheriff's Deputies Charged with Murdering Inmate.* News. Crime and Public Safety. The Virginia Pilot (Jan. 3, 2025), https://www.pilotonline.com/2025/01/03/3-former-virginia-beach-sheriffs-deputies-charged-with-murdering-inmate/?lctg=14815426C5E0A542943F341333&utm_email=14815426C5E0A542943F341333&active=no&utm_source=newsletter&utm_medium=email&utm_term=https%3a%2f%2fwww.pilotonline.com%2f2025%2f01%2f03%2f3-former-virginia-beach-sheriffs-deputies-charged-with-murdering-inmate%2f&utm_campaign=trib-virginian_pilot-breaking_news-nl&utm_content=Alerts.

[23] DYRS PPM: Use of Physical Intervention § II, at 1.

[24] DEP'T YOUTH REHAB. SERVS., POL'Y & PROCEDURE MANUAL, Use of Mechanical Restraints § II (Mar. 13, 2019) [hereinafter: DYRS PPM: Use of Mechanical Restraints].

[25] DEP'T YOUTH REHAB. SERVS., POL'Y & PROCEDURE MANUAL, Room Confinement § II (Nov. 6, 2018).

[26] DYRS PPM: Room Confinement.

[27] *See* Denise Marshall, *Trauma-Informed Care: Child Safety Without Seclusion and Restraint*, COUNCIL OF PARENT ATTORNEYS AND ADVOCATES (Dec. 9, 2015), https://www.copaa.org/blogpost/895540/234517/Trauma-Informed-Care-Child-Safety-Without-Seclusion-and-Restraint.

[28] Amanda Wik*, Elevating Patient/Staff Safety in State Psychiatric Hospitals*, NAT'L ASSOC. OF STATE MENTAL HEALTH PROG. DIRECTORS RSCH. INST. 1, 4 (Jan. 2018), https://www.nri-inc.org/media/1465/2018-elevatingpatient_endnotesfinal.pdf; *see also* Jo Wilton, Briefing 54: Trauma, Challenging Behaviour and Restrictive Interventions in Schools, CENTRE FOR MENTAL HEALTH 1, 4 (Jan. 2020), https://www.centreformentalhealth.org.uk/sites/default/files/2020-01/Briefing_54_traumainformed%20schools0.pdf.

[29] Disability Rights D.C., *Youth at Risk: Dangerous Restraints and Excessive Seclusions at DYRS Facilities,* 22 (Nov. 2023).

[30] Juvenile Justice Reform Act of 2017, P.L. No. 115-385, § 205 (2018) ("A state's juvenile justice and delinquency plan must contain additional components, including plans to: provide alternatives to detention, reduce children in secure detention and corrections facilities, engage family members, use community-based services, promote evidence-based and trauma-informed programs and practices, and limit the use of restraints on pregnant juvenile offenders.") 34 U.S.C.A. § 11103(40) (2018)(defining trauma-informed care); *see also* 34 U.S.C.A. § 11102(4)

(2018) (stating the purpose "to support a continuum of evidence-based or promising programs ((including delinquency prevention, intervention, mental health, behavioral health and substance abuse treatment, family services, and services for children exposed to violence)) that are trauma informed, reflect the science of adolescent development, and are designed to meet the needs of at-risk youth and youth who come into contact with the justice system).

[31] D.C. Code § 5-125.03.

[32] D.C. Code § 1-125.02(3)(A).

[33] D.C. Code § 1-125.02(5).

[34] D.C. Code § 1-125.02(3)(A); s*ee also* District of Columbia Police Reform Commission, *Decentering Police to Improve Public Safety*, 120 (Apr. 1, 2021), https://dccouncil.gov/wp-content/uploads/2021/04/Police-Reform-Commission-Full-Report.pdf ("[B]ecause there are restraints other than neck restraints that cause asphyxia, including certain restraints that cause positional asphyxia (e.g., 'prone restraint,'…), the prohibited types of restraints should be expanded beyond 'neck restraints.'"); https://ocfs.ny.gov/programs/youth/detention/directives/Ending-Prone-Restraints.pdf.

[35] DYRS PPM: Use of Physical Intervention § VI.B at 3.

[36] DYRS PPM: Use of Physical Intervention, §§ II.A-B & VI.A.-B, at 2-3.

[37] DYRS PPM: Use of Physical Intervention § VI.A., at 2 (emphasis added).

[38] *See* Analysis of Videotape Footage at 8-15; *see also* DYRS PPM: Use of Physical Intervention § VI.A.B. at 3; *see also* D.C. Code §§ 1-125.02-.03*; see also* District of Columbia Police Reform Commission, Decentering Police to Improve Public Safety, 120 (Apr. 1, 2021), https://dccouncil.gov/wp-content/uploads/2021/04/Police-Reform-Commission-Full-Report.pdf.

[39] OII Investigative Report (Spring 2024) at 20-21.

[40] *Id*. at 20. In the video footage, supervisory staff can be identified as wearing white shirts while other staff wear blue shirts. (DRDC interview with DYRS staff Feb. 6, 2025).

[41] BLUR_Cam 38 at 00:00:00. [hereinafter: YSC Incident Report (Spring 2024)].

[42] BLUR_Cam 38 at 00:00:00.

[43] *Id.* at 00:01:36.

[44] *Id.* at 00:03:01; *see also* YSC Incident Report (Spring 2024).

[45] BLUR_Cam 38 at 00:06:45; *see also* BLUR_Cam 141 at 00:07:09.

[46] BLUR_Cam 38 at 00:09:07.

[47] *Id.* at 00:09:08.

[48] *Id.* at 00:09:10.

[49] *Id.* at 09:09:00.

[50] *Id.* at 00:09:39.

[51] *Id.*

[52] *Id.* at 00:09:55.

[53] *Id.* at 00:09:57.

[54] *Id.* at 00:09:58.

[55] *Id.* at 00:10:13. The videotape provides a partially obstructed view of the following interaction.

[56] *Id.* at 00:10:52.

[57] *Id.* at 00:10:38.

[58] *Id.* at 00:10:44.
[59] *Id.* at 00:10:59.
[60] *Id.* at 00:11:01.
[61] *Id*. at 00:11:14.
[62] *Id.* at 00:11:18.
[63] *Id.* at 00:11:34.
[64] *Id.* at 00:11:35.
[65] *Id.* at 00:11:42.
[66] *Id*. at 00:11:43. In the YSC Incident Report (Spring 2024), a staff member refer to this move as an "upper torso," restraint based on "safe crisis management."
[67] *Id.* at 00:00:53.
[68] *Id*. at 00:00:53 (until 00:36:20).
[69] *Id.* at 00:01:06 (throughout the entirety of the video footage).
[70] *Id.* at 00:48:03.
[71] *Id.*
[72] BLUR_Cam 141 at 00:48:16.
[73] *Id.* at 00:48:18.
[74] *Id.* at 00:48:20.
[75] *Id.* at 00:48:18.
[76] *Id.* at 00:48:24.
[77] *Id.* at 00:48:18 (ending at 00:48:28).
[78] *Id*. at 00:48:30.
[79] YSC Incident Report (Spring 2024).
[80] OII Investigative Report (Spring 2024) at 10, 11. A prone position refers to someone lying on their stomach, often with their hands behind their back. Placing an individual into a prone position can compress their chest, making it difficult or impossible to breathe, which can lead to cardiac arrest. Victor Weedn, Alon Steinberg, & Pete Speth, *Prone restraint cardiac arrest in in-custody and arrest-related deaths*, 67(5) J. FORENSIC SCI. 1899, 1906-09 (2022).
[81] DRDC Outreach Visit (May 3, 2024) (including interview with Jesse).
[82] OII Investigative Report (Spring 2024) at 5.
[83] YSC Medical Report (2024) at 1718-19.
[84] OII Investigative Report (Spring 2024) at 5.
[85] *Id.* at 1, 5.
[86] *Id.* at 6-8.
[87] *Id.* at 8, 9, 11.
[88] *Id.* at 8, 11.
[89] *Id.* at 11.
[90] YSC Medical Records (2024) at 1718.
[91] OII Investigative Report (Spring 2024) at 15.
[92] *Id.* at 20; *see also* DYRS PPM: Use of Physical Intervention § VI.B at 3. District of Columbia Police Reform Commission, Decentering Police to Improve Public Safety, 120 (Apr. 1, 2021), https://dccouncil.gov/wp-content/uploads/2021/04/Police-Reform-Commission-Full-Report.pdf.

[93] DYRS PPM: Use of Physical Intervention § II.A, at 1. (*emphasis added*).
[94] DYRS PPM: Use of Mechanical Restraints § II.B, at 1.
[95] DYRS PPM: Room Confinement § V.A. at 2.
[96] *See* OII Investigative Report (Spring 2024); *see also* YSC Incident Report (Spring 2024).
[97] BLUR_Cam38 at 00:09:09.
[98] DYRS PPM: Unusual Incident Reporting § VI.A at 2.
[99] OII Investigative Report (Spring 2024) at 21. When asked why the proper reporting was not completed, staff members provided reasons including the roles and responsibilities were not clear, they got too busy, and that they entered the notes elsewhere. *Id.* at 6, 8-9.
[100] OII Investigative Report (Spring 2024). One involved staff member reported his forearm did "end up" around Jesse's neck, but it was not a chokehold because "it was really on his shoulder." *Id.* at 10.
[101] DYRS PPM: Use of Physical Intervention § VI.E at 3; DYRS PPM: Use of Mechanical Restraints § V.H. at 4.
[102] DYRS PPM: Use of Physical Intervention § VI.B at 3.
[103] BLUR_Cam 93.mp4 timed at 00:00:27 (Fall 2024) (where the video footage begins at 00:00:00 and ends at 00:13:03).
[104] BLUR_Cam149 at 00:01:11; *see also* BLUR_Cam 92_1 timed at 00:00:50 (Fall 2024) (where the video footage begins at 00:00:00 and ends at 00:12:38).
[105] BLUR_Cam 149 at 00:01:19.
[106] *Id.*
[107] *Id.* at 00:01:45.
[108] BLUR_Cam 92_1 at 00:01:09.
[109] *Id.* at 00:01:26.
[110] *Id.* at 00:01:35.
[111] *Id.* at 00:01:44; *see also* BLUR_Cam 149 at 00:01:53-00:02:02.
[112] BLUR_ Cam 149 at 00:02:04.
[113] *Id.* at 00:03:49.
[114] *Id.* at 00:04:02.
[115] *Id.* at 00:04:18.
[116] *Id*. at 00:01:45-00:10:11.
[117] *Id.* at 00:10:11.
[118] *Id.* at 00:10:36.
[119] *Id.* at 00:10:44.
[120] *Id.*
[121] *Id.* at 00:11:10-00:11:18.
[122] *Id.* at 00:11:18-00:11:37.
[123] *Id.* at 00:11:43.
[124] *Id.* at 00:12:03.
[125] *Id.* at 00:13:00.
[126] YSC Major Incident Assessment Report (Fall 2024).
[127] DYRS PPM: Use of Physical Intervention § VI.A at 2.

[128] OFF. INTERNAL INTEGRITY (OII), Investigative Report: Youth Services Center 2 (Fall 2024) [hereinafter: OII Investigative Report (Incident 1, Fall 2024). at 9-13.
[129] *Id.* at 12-13.
[130] *Id.* at 9, 11.
[131] *Id.*
[132] *See supra* FNs 19-22; DYRS PPM: Use of Physical Intervention §VI.B. at 3; D.C. Code 1-125.02(3)(B).
[133] DYRS PPM: Unusual Incident Reporting § VI.A at 2.
[134] BLUR_Cam 93_1 at 00:01 (where the video footage begins at 00:00:00 and ends at 00:35:54).
[135] *Id.* at 00:01:03.
[136] *Id.* at 00:01:27.
[137] *Id.* at 00:01:32.
[138] *Id.* at 00:01:55.
[139] *Id.* at 00:02:02.
[140] *Id.* at 00:02:13.
[141] *Id.* at 00:02:13-00:04:27.
[142] *Id.* at 00:04:27.
[143] *Id.* at 00:04:34.
[144] *Id.* at 00:04:36.
[145] *Id.* at 00:04:38.
[146] BLUR_Cam149_1 at 00:05:06 (where the video footage begins at 00:00:00 and ends at 00:36:02).
[147] *Id.* at 00:04:39 until 00:09:18. At one point, the staff member who was hit earlier appears to say something to which two staff members point him away from Jesse. *Id.* Other youth are seen looking out of their room windows. BLUR_Cam149. at 00:05:44-00:05:50.
[148] BLUR_Cam 93_1 at 00:05:53, 00:06:45
[149] *Id.* at 00:04:39-00:09:18.
[150] *Id.* at 00:08:30-00:09:18.
[151] *Id.*
[152] *Id.*
[153] *Id.* at 00:08:38.
[154] *Id.* at 00:09:16.
[155] *Id.* at 00:09:30-00:11:50.
[156] *Id.* at 00:11:19.
[157] *Id*. at 00:11:50.
[158] *Id.*
[159] BLUR_Cam 149_1 at 00:12:10.
[160] *Id.* at 00:12:23; *see also* BLUR_Cam 93_1 at 00:12:22.
[161] BLUR_Cam 93_1 at 00:12:23.
[162]*Id.* at 00:13:54, 00:15:16. The same staff member switches to the other side of Jesse, using his leg on Jesse's lower body and his hand on Jesse's back to support him as he switches to continue the restraint. *See* BLUR_Cam 93_1 at 00:15:16.

[163] *Id.* at 00:12:23-00:15:41.
[164] *Id.* at 00:15:44.
[165] BLUR_Cam 149_1 at 00:15:46.
[166] BLUR_Cam 92_1 at 00:15:25-00:15:30.
[167] *Id.* at -00:15:30.
[168] *Id.* at 00:15:30-00:34:57.
[169] *See supra* FNs 19-22.
[170] DYRS PPM: Use of Physical Intervention § VI.A at 2.
[171] *Id.*
[172] *See supra* FNs 19-22.
[173] DYRS PPM: Use of Physical Intervention § II.A at 1.
[174] DYRS PPM: Use of Physical intervention § VI at 2.
[175] *See* 45 C.F.R. § 1326.27(c); 42 C.F.R. § 51.42(c).
[176] DYRS PPM: Room Confinement.; *see also* D.C. Code § 24-912 (Dec. 20, 2018).
[177] D.C. Code § 24-912(e).
[178] DYRS PPM: Room Confinement § V.B. at 2.
[179] DYRS PPM: Room Confinement § V.D.2. at 3.
[180] *Id* at § V.D.3. at 3. The policy also states that seclusion as result of a single incident, may not exceed 72 hours, unless declared written emergency is issued by the Superintendent. DYRS PPM: Room Confinement § V.D.5. at 4.
[181] DYRS PPM: Room Confinement § V.D.4. at 3.
[182] Disability Rights DC, *Youth at Risk: Dangerous Restraints and Excessive Seclusion at DYRS Facilities*, 17-18 (November 2023). The D.C. Office of Independent Juvenile Justice Oversight (OIJJFO) also reported that YSC implemented a facility-wide lockdown in December 2022, where the youth were held in their rooms for 22-23 hours a day, being permitted to leave their rooms about every 10 hours. Moreover, children were forced to conduct their school instruction through the window in the doors of their rooms. Jenny Gathright and Colleen Grablick, '*Why is My Child Always on Lockdown?:' Confinement at D.C.'s Youth Jail Worries Parents, Advocates* (Jul. 21, 2023), https://dcist.com/story/23/07/21/dc-youth-detention-confinement-staffing-crisis/.
[183] *See* Denise Marshall, *Trauma-Informed Care: Child Safety Without Seclusion and Restraint*, COUNCIL OF PARENT ATTORNEYS AND ADVOCATES (Dec. 9, 2015), https://www.copaa.org/blogpost/895540/234517/Trauma-Informed-Care-Child-Safety-Without-Seclusion-and-Restraint.
[184] DEPT' YOUTH REHAB. SERVS., POL'Y AND PROCEDURE MANUAL, Room Confinement, § II, 1 (November 6, 2018).
[185] DRDC Monitoring Visit (June 20, 2024); (July 2, 2024); (Nov. 21, 2024).
[186] *Id.*
[187] D.C. Code § 24-912 (2018); *see also* DYRS PPM: Room Confinement §V.B,.D. at 2-4.
[188] DEP'T YOUTH REHAB. SERVS., Mission. About DYRS (last visited Nov. 11, 2024), https://dyrs.dc.gov/page/about-dyrs-0#:~:text=All%20youth%20should%20be%20connected,opportunities%20for%20growth%20and%20change.

[189] DYRS PPM: Use of Physical Intervention § VI.F, at 3.
[190] Joan B. Gillece, *Understanding the Effects of Trauma on Lives of Offenders,* 71:1 CORRECTIONS TODAY 48 (Feb. 2009).
[191] D.C.M.R. 22-A § 505; District of Columbia Public Schools, Restraint and Seclusion Policy, 4 (Aug. 29, 2022), https://dcps.dc.gov/sites/default/files/dc/sites/dcps/publication/attachments/Restraint%20and%20Seclusion%20Policy_FINAL_Signed.pdf; PIW Policy NSG.168 (4.1) ("In no case may a patient be taken to the floor or held in a prone position."); St. Elizabeths Hospital Policy 103 § III.D.2.e.
[192] *See supra* FNs 19-22.
[193] *Id.*
[194] DEP'T YOUTH REHAB. SERVS., POL'Y AND PROCEDURE MANUAL, Room Confinement, § II, 1 (November 6, 2018).
[195] DYRS PPM: Room Confinement § V.D.5.
[196] D.C. Code Ann. § 24-912 e.1.