

**Investigation into the Circumstances Surrounding the Injuries
Sustained by a Youth While in the Detention Unit of the
Woodside Juvenile Rehabilitation Facility in 2006**

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I Introduction

This report presents the results of the investigation conducted by Vermont Protection & Advocacy, Inc. (VP&A) into the circumstances surrounding injuries sustained by a youth while in detention, including his broken wrist, sustained during a use of force incident on September 26, 2006. **VP&A wishes to emphasize that the facts discussed herein relate to the events relevant to the youth's stay in D-wing in the summer and fall of 2006. This report does not address the significant efforts D-wing has made to respond to criticisms in reports written by both VP&A and Dr. David Roush in 2006 and the impact these efforts have had on the current situation facing youth with disabilities detained in D-wing.**

Between June and October 2006 the youth was a child in the custody of the Department for Children and Families' (DCF) who was placed in D-wing. This was the youth's fifth admission to D-wing and D-wing staff were aware from past experience that the youth presented with significant disabilities. The youth had a difficult time at D-wing prior to the September 26th use of force episode, including a use of force episode on July 8, 2006, resulting in self-reported injury to him.

On September 26, 2006 the youth was the subject of a use of force that resulted in serious physical injury, a broken wrist, and likely emotional trauma. This report will discuss how the youth got to D-wing, what D-wing staff and DCF did to accommodate and provide appropriate treatment for the

youth while he was there, and the circumstances surrounding the two reported use of force incidents.

Overall we conclude that efforts were insufficient to provide adequate services to the youth during his 109 day stay in D-wing. From medical to educational to behavior management and trauma therapy perspectives, D-wing and DCF failed to significantly plan for, implement, and update their provision of services to the youth during his stay at D-wing. The absence of a comprehensive approach to the youth's documented treatment needs appear to have contributed greatly to the use of force that resulted in significant injury to the youth on September 26, 2006. It also appears that the quality assurance mechanisms and oversight in place to analyze the circumstances of the youth's restraint failed to provide an opportunity to focus on critical analysis and systems improvement.

VP&A acknowledges the many years of service that the staff and administration of Woodside and D-wing have provided to the community of Vermont. D-wing has maintained an excellent track record of few serious physical injuries to youth detained at D-wing over the last 19 years. VP&A also acknowledges that the youth is a child who presents his caretakers with enormously difficult and emotionally charged issues and crises. With that position clearly identified, the remaining conclusion of our review is that appropriate screening, evaluation, implementation and oversight of necessary mental health and special education related services could prevent injuries to children like the youth that are otherwise likely to occur. D-wing staff and administrators have pointed out that the youth's behaviors were difficult to manage while in the community and that he was subject to daily

restraints at his previous placement. While generally accurate, VP&A does not consider the fact that the youth had previously been restrained almost daily at his previous placement to have any mitigating effect on the lack of mental health treatment and appropriate education provided in D-wing, the significant instances of isolation the youth experienced in his room, and the serious injury he was subject to while in D-wing for only 109 days.

II Background

A Organizational Entities

- i) Vermont Protection & Advocacy, Inc. (VP&A) is a federally funded, not-for-profit organization mandated to investigate abuse, neglect and serious rights' violations affecting people with disabilities.
- ii) Woodside Juvenile Rehabilitation is operated and funded by the Department for Children and Families in the Vermont Agency of Human Services. Woodside Juvenile Rehabilitation Facility operates two programs: The detention unit (also referred to as D-wing) and the treatment program (referred to as R-wing). At all times relevant to this report, the youth was held in D-wing.
- iii) The Laraway Substitute Care (Sub-care) program, based in Morrisville, Vermont, is licensed by the Department for Children and Families as a child-placing agency. Laraway trains and

supports foster homes for children who are in the custody of the State of Vermont. The Sub-care Program provides services to many youths who have experienced intense psychological trauma, severe neglect, physical, and sexual abuse. Laraway provides case managers, mentors, foster parents, respite providers, individual and group and family therapists who work as a team to assist the youth in regaining a sense of self by developing strategies to address each youth's specific treatment needs.

B Vermont Protection & Advocacy's Investigation

VP&A's investigation of this case included the following:

- i) Review of D-wing staff notes, medical records, educational records, court documents, internal electronic messages, incident reports, and internal policies and procedures from Woodside and interviews with staff;
- ii) Review of case notes, court documents, educational records, social worker's notes, and evaluations from the Department for Children and Families in Morrisville, Vermont and an interview with the youth's social worker;
- iii) Review of treatment plans, medical records, educational records, and case manager notes from the Laraway Program located in Morrisville, Vermont, and interviews with staff and providers; and

iv) Review of the Agency of Human Services Investigation report.

III The youth

The youth was born in Lamoille County, Vermont in 1993 and lived with his family until 2002 when, at 9 years old, he was ordered into the State's custody due to severe abuse and neglect. DCF records indicate that the youth's mother lost custody of the youth and her other children after her husband died of cancer and her mental health conditions left her unable to care for them adequately. DCF records also document that the youth suffered tremendously as a result of his parents' hardships which produced the abuse and neglect that eventually led to termination of parental rights. The youth was diagnosed with severe trauma-related and attachment-related impairments after several evaluations. Records indicate that the youth was not only exposed to violence at home but that he also experienced forms of violence in school. Once in DCF custody the youth became a child for whom finding a placement was increasingly difficult due to his behaviors and DCF's inability to effectively respond to them. The youth is a child struggling with disabilities well known to his custodians in DCF and for whom Trauma Evaluations, Individual Education Plans (IEPs) and psychiatric medications and other treatments have been prescribed.

A DCF History

In May 2002, Lamoille County Family Court found the youth and his siblings to be Children in Need of Care and Supervision. In May 2004, an order terminating parental rights was issued and the youth was released for

adoption. In October 2004 the youth was assigned to a social worker as part of the process to find him a permanent placement with an adoptive family.

Between 2002 and 2006 all efforts to find the youth a suitable family to adopt him failed. Apparently none of the pre-adoptive/foster placements were equipped to care for him. During those years, each time the youth grew close to his foster care placements, his well-documented impairments and special needs proved to require more intense supervision and therapy than was available and the placements failed. Over the course of 4 years, including his foster and respite placements, the youth had a total of 17 placement changes. These moves included several placements at the Brattleboro Retreat and D-wing. He was admitted to the Retreat three times, in May 2002, June 2002, and again in February 2006. Some of these admissions were for self-harming behaviors such as eating “five yards of dental floss” and “punching himself in the face until he has a bloody nose.”

The youth was admitted to Woodside for 4 short periods while in DCF custody prior to his June 2006 Woodside admission. After each of these admissions, the youth had been returned to his foster care placements. VP&A’s investigation is focused on his 5th placement on D-wing from June 26, 2006 to October 12, 2006, after which the youth was placed in an out of state residential program.

B Trauma and Behavior - Related Evaluations

The youth has a history of receiving treatment for a variety of special needs while in DCF custody. In April 2003, DCF identified that the youth required extensive educational services, weekly mental health case

management, behavioral planning, psychiatric services, and individualized therapy.

In August 2004, the youth began seeing a therapist to address his trauma history and difficulties attaching to people. In May 2005 DCF determined that the youth would benefit from having a male therapist who specialized in Attachment Disorders. A therapist was hired to begin his therapeutic relationship with the youth. The therapist also provided consultations to DCF and his treatment team until July 20, 2006, during the youth's last admission to Woodside. His consultations with the youth's service providers focused on the youth's post-Woodside placement. The therapist indicated that neither the youth's social worker nor his treatment team contacted him about the youth's mental health treatment at Woodside.

In March 2006, DCF hired a professional from the New England Counseling and Trauma Center, to conduct a psychosexual evaluation of the youth. This evaluation is more usefully understood as a "Trauma Evaluation" due to its conclusions and recommendations. The request for the evaluation was prompted by the youth's sexually acting-out behaviors that were thought to be a result of the alleged sexual abuse he experienced.

The Trauma Evaluation identified that the youth "has a history of chronic and early-onset trauma exposures" including exposure to guns, being handcuffed, isolated, deprived of food and a clean environment, and poor to no parental supervision. The evaluation documents that the youth "experienced significant loss and disruption in his primary attachments" due to his father's death and the removal from his mother's custody. It also

identified that the youth may be unable to regulate his trauma-related behaviors; records document the youth “appears to be experiencing complex trauma that has resulted in a loss of his core capacity for self-regulation and interpersonal relatedness... [The youth’s] social skills are markedly underdeveloped and the quality of his relationships with others is poor. [The youth’s] behaviors appear to be impulsive in nature, immature, and more for the shock value than anything else...”

The Trauma Evaluation recommended that the youth should “have appropriate adult supervision” and the adults “should be aware of his acting-out and self-harming behaviors and should be in a position to directly and respectfully challenge/ confront his behaviors and to provide consistent support to him.” One recommendation emphasizes the importance for caregivers and treatment providers to review the youth and his siblings’ files to better understand their long history of abuse and neglect.

The Trauma Evaluation recommended that the youth participate in specific counseling to focus on decreasing particular behaviors. The evaluation specifically identified that a clinician should work with the youth to develop a plan to minimize his acting-out behaviors and for the youth to have a list of safety rules focusing on daily living skills with the help of appropriate adult supervision in the home and school settings. The youth’s “safety plan should clearly outline” his “support members in the school setting.” The plan “should identify the reasonable goals and expectations.” The evaluation documents that “it is imperative that school personnel understand that the youth may experience an increase in anxiety and stress...” The evaluation also specified that the youth should continue work with a trauma

therapist to address his early childhood and that his “mental health presentation” should be “closely monitored” based on his mother’s mental illnesses.

While the youth attended elementary school, the youth’s treatment team hired a consultant to assist them with addressing the youth’s outbursts that resulted in almost daily restraints. A behavioral consultant was hired to develop “environmental/ behavioral approaches” for the youth while at school. The behavioral plan in March 2006 identified that the youth is “highly sensitive” to almost any type of correction and often corrections can be “an antecedent for challenging behaviors.” The consultant made many specific recommendations and developed protocols for responding to the youth when he was upset or disruptive. These suggestions included that, when correcting the youth, the person directing the youth should balance their remarks to the youth by saying something positive “before and after the correction”, that the youth should be given time to calm down away from peers with specific calming techniques and without an adult talking to him, and that he should have a squishy ball to squeeze when he gets fidgety. Regarding how to respond to the youth when he is being disruptive and allowed to go to a place to calm down, the consultant recommended the adult “not talk with the youth or interact in any way” unless the youth or the adult is in imminent danger. The consultant also recommended to “only use protective restraint when there is imminent danger of the youth hurting himself or another person.”

During VP&A’s interview with the youth’s attachment therapist he reiterated concerns and suggestions similar to those described in the trauma

evaluation and in the consultant's behavioral plan. The therapist identified the youth as "a scared little guy" who is in a constant state of "fight or flight" and that he will subconsciously solicit an adult's anger because he is only familiar with those kinds of feelings.

School records documenting the youth's need for space and quiet time when he was upset indicate that others on his treatment team also identified similar concerns and suggestions. Records indicate that the youth's treatment team recognized that the youth "seeks negative attention from adults during crisis to fuel his escalation." His treatment team identified that it is best to "minimize" their attention to the youth as a de-escalation technique.

VP&A found little indication in the D-wing records and our interviews that the information contained in all of these various evaluations, reports and plans was conveyed to or discussed with D-wing staff.

C Special Education

The youth's November 2005 to November 2006 Individual Education Plan (IEP) documents that he required a number of professionals and agencies providing services to accommodate his disabilities and provide for his special needs. The IEPs identify the youth's learning disabilities, attachment disorder, trauma history, and related behavioral needs. The IEPs identify the youth to "be learning impaired with significant emotional impediments to his learning" and his IQ is scored to be a borderline of 78.

The November 2005 IEP required that the youth have special instructions and modified assignments and assessments and additional specific supports

such as a scribe for long written projects. The November 2005 IEP recommends that the youth receive “1-on-1 adult supervision during special activities to help him maintain appropriate behavior” and that he have a “specific behavior plan with clear expectations and consequences to help him manage his anger and frustrations.” The IEP emphasized that “staff working with the youth should be trained concerning Reactive Attachment Disorder and Post Traumatic Stress Disorder.”

D Diagnosis and Medications

An April 3, 2006 evaluation at Retreat Healthcare by the doctor identified the following diagnoses for the youth:

- Axis I: Attachment Reactive Disorder¹
Post Traumatic Stress Disorder²
Attention Deficit Disorder³
- Axis II: Borderline Intellectual Functioning.
- Axis III: Gastro esophageal Reflux Disease

¹ Reactive Attachment Disorder (RAD) is a mental health disorder in which a child is unable to form healthy social relationships, particularly with a primary caregiver. Often children with RAD will seem charming and helpless to outsiders, while waging a campaign of terror within the family. RAD is frequently seen in children who have had inconsistent or abusive care in early childhood, including children adopted from orphanages or foster care. <http://specialchildren.about.com/od/gettingadiagnosis/g/RAD.htm>

² Post-traumatic stress disorder (PTSD) is a term for certain severe psychological consequences of exposure to, or confrontation with, stressful events that the person experiences as highly traumatic. PTSD may be triggered by an external factor or factors. Its symptoms can include the following: nightmares, flashbacks, emotional detachment or numbing of feelings (emotional self-mortification or dissociation), insomnia, avoidance of reminders and extreme distress when exposed to the reminders ("triggers"), loss of appetite, irritability, hypervigilance, memory loss (may appear as difficulty paying attention), excessive startle response, clinical depression, and anxiety. It is also possible for a person suffering from PTSD to exhibit one or more other comorbid psychiatric disorders; these disorders often include clinical depression (or bipolar disorder), general anxiety disorder, and a variety of addictions. http://en.wikipedia.org/wiki/Post_traumatic_stress_disorder

³ Attention-Deficit/Hyperactivity Disorder (ADHD) is generally considered to be a developmental disorder, largely neurological in nature, affecting 3–5 percent of the population. The disorder is characterized by a persistent pattern of inattention and/or hyperactivity-impulsivity. ADHD initially appears in childhood and manifests itself with symptoms such as hyperactivity, forgetfulness, poor impulse control, and distractibility. http://en.wikipedia.org/wiki/Attention_deficit

Asthma

- Axis IV: History of neglect, school stresses, foster home placement
- Axis V: Global Assessment of Functioning= 35⁴

The available records indicate that the doctor prescribed and monitored the youth's medications on a monthly basis for at least 6 months prior to the youth's June 2006 admission to D-wing. The doctor's records indicate her concerns about the youth's weight gain and issues related to monitoring his anti-psychotic medications.

Woodside's records indicate that on July 7, 2006 the youth was prescribed:

- Quafacine 1 mg po TID
- Concerta 72 mg po Q am
- Risperdal 1 mg po TID
- Citalopram 20mg po q am (decreased to 10 mg on 7/7/06)
- Zyprexa 2.5 mg @ 1400 & 5mg@hs PRN
- Albuterol inhaler 2 puffs
- Flovent inhaler 1 puff 2 x 1 day

E Circumstances Directly Preceding the Youth's June 2006 Admission to D-wing

⁴ The DSM –IV-TR defines Global Assessment of Functioning in a scaling range which considers the “psychological, social, and occupational functioning on a hypothetical continuum of mental health illnesses.” In reviewing the youth's diagnosis to be at the 35 scale, he is defined by DSM to be a person with “some impairment in reality or major impairment in several areas,” such as in “work or school, judgment, thinking or mood.”

Despite DCF's attempts to try new approaches to his education and home life, the youth was not doing well in June of 2006. His foster mother reported to the youth's caseworker that his behaviors were escalating and she had doubts about the adequacy of her home as a placement for him. The foster mother stated that she was not sure if they "are going to be able to hang in there... aren't sure if they can keep him safe..." The youth's treatment team was also aware of his escalating behavior at school where he was experiencing almost daily restraints.

The treatment team consulted with the youth's attachment and trauma therapist on several occasions in June 2006. Records indicate the therapist assessed the youth's behaviors and provided recommendations to the team on how to address them at his foster care placement. The therapist informed the team that the youth's "behaviors now are about attachment" and "we need to push through if the youth is ever going to make it through and make it in a family." He suggested DCF put more effort into the placement and opined that the youth's problems were not complex psychiatric or behavioral issues but more about him trying to figure out how family works. He reiterated that the use of restraints take an emotional toll on the youth and causes secondary trauma. He recommended against putting the youth into a "90 day placement" and instead favored augmenting services to the current placement, including an additional full-time adult, to help address the youth's needs.

On June 24, 2006, law enforcement and mental health screeners were called to respond to the youth after he was reportedly "aggressive and exposed himself" at his foster placement. The responding officer refused to charge

the youth with a crime or delinquent act and stated that his primary objective was to get the youth out of the home for the night and have DCF place him.

On June 25, 2006, the youth's social worker contacted DCF's Central Office to see if DCF had an immediate residential placement for the youth, specifically at NFI's Shelburne House, or any other option. With no other placement available, DCF agreed to place the youth at Woodside until a better option arose. DCF also informed the social worker that Shelburne House would not have an opening until December 2006.

On June 26, 2006, placement for the youth became an emergency situation for DCF. The youth's foster placement notified DCF that they could no longer provide a home for him after he made false allegations against them and hurt their dog. DCF case notes document that the youth's Case Manager from Laraway was "not sure what to do" because the youth was not listed as a delinquent in the DCF computer, and thus could not be sent to D-wing. DCF case notes document that the District Director agreed to "have secretaries change his status in the computer to a DC (delinquent child) immediately" in order to facilitate placing the youth in D-wing. The youth was placed in D-wing on June 26, 2006. The youth was maintained at D-wing under court order until October 6, 2006 when the Judge agreed to place the youth out of state. The youth was released from D-wing on October 12, 2006 when DCF found an out of state placement for him.

IV Provision of Therapeutic Services and Accommodations in D-wing

A Notice of the youth's Special Needs and Circumstances

D-wing staff had prior knowledge and experience with the youth due to his four previous stays at Woodside. Records indicate that during his January 2006 placement in D-wing, the youth's social worker informed a D-wing staff member that the youth had difficulty reading and writing after the staff member complained that the youth was "refusing to do his intake and calling the staff names." D-wing's intake process involves requiring the youth to read and write the orientation handbook. If the youth has been admitted to Woodside more than once, as the youth had, each time they are readmitted they are expected to rewrite the handbook. The youth is required to be secluded until the rewrite is accomplished. This policy appears to be punitive in that its intent is to dissuade youth from returning to Woodside. Records indicate that on January 4, 2006, as a result of the social worker informing the D-wing staff member that the intake process might be difficult for the youth, the D-wing staff member agreed to provide some special assistance to the youth through the intake process. No records indicate what the D-wing staff member did to accommodate the youth's learning disabilities.

At the time of the youth's last admission to Woodside, records indicate that D-wing staff knew the youth was admitted under special conditions and that he could be on D-wing for several months. In June 2006 one staff member noted that the youth's "order indicates [he] may stay here until appropriate placement, although I believe special permission must be given by Waterbury bigwigs as he is only 12YOA (according to policy)." Another record documented a conversation with the youth's social worker, "talked to [the social worker], the long term plan is [to place the youth at the]

Shelburne house 6 months out. Short term plan is staff a home where [the youth] could stay. Looking at house and piecing staff together...” On June 28, 2006, records indicate that the youth was anxious to leave Woodside and asked his social worker if he would be out by his birthday. She informed him that it was DCF’s plan “to have him remain at Woodside for the time being so we can assure his safety...while they find appropriate plan for him.” While generally acknowledging that the youth would be in D-wing for a while, records do not demonstrate that provisions were made to evaluate the need for and provide legally required and appropriate accommodations during his extended stay.

The nurse was made aware of the youth’s disabilities and special needs in September of 2004, during the youth’s first admission to Woodside, by the youth’s acting psychiatrist at the time. A September 13, 2004 physician’s record documents that the doctor informed the nurse of the youth’s IQ level of 78, his mother’s mental health conditions, and his father’s abuse and control of the children. The nurse’s June 26, 2006 nursing note indicates that she was aware of his psychiatric medications, his prior placement at Laraway School, and his extreme attachment disorder.

B Special Education in D-wing

According to Woodside’s Special Education Procedures “the Individualized Education Programs (IEP's) of students who are handicapped and eligible for special education services are implemented as developed by the adolescent's sending school district. If it is not possible to implement the resident's IEP as it was written by the responsible school district, Woodside School staff

will assist the responsible school district in the development of an interim IEP.” D-wing staff assert that the youth received appropriate IEP services and that his education while in D-wing for 109 days conformed to an agreement D-wing made with the Vermont Department of Education in 1995, identified as DOE Information Circular #95-185. There was no acknowledgment by D-wing staff that Dr. Roush, an outside consultant hired by the Department to review the detention program in 1988 and 2006, VP&A, and the Department itself have basically agreed that the special education facilities in D-wing are not adequate. In addition, D-wing staff rely on an agreement with DOE that is based on unrealistic assumptions that the average length of stay is eight days and the maximum is sixty days. Neither of those assumptions is accurate or relevant to the current use of this facility, including the youth’s 109 day stay. While entities other than D-wing special education staff are delegated responsibilities under the DOE Information Circular, D-wing staff had a duty to reach out for help if the IEP was not effective in the youth’s new setting. VP&A did not find sufficient detail in the records and other sources of information that we reviewed to confirm that the youth’s IEP was being adequately implemented. The records indicate the D-wing educators developed their own educational plan for the youth without documenting either the impact of the information gained from outside sources or the specific strategies and tactics to be applied in pursuit of fulfilling the requirements of his IEP in the challenging circumstances presented by D-wing’s physical plant and detention environment.

The records provided to VP&A did not adequately indicate specific actions taken by the educator or other D-wing staff to communicate with the youth’s

school district to discuss problems they were experiencing or the development of an interim IEP. Pursuant to the 1995 DOE Information Circular referenced above, these actions were required and should have been documented adequately if they occurred. VP&A did review some records from prior educational placements in the records provided to us from D-wing which demonstrated that there was an effort made to obtain them. D-wing staff reported that these efforts were hindered by the fact that school personnel were difficult to reach over the summer months. The documentation provided demonstrates that efforts to communicate with the youth's LEA and obtain prior records started after the youth had been at D-wing for about two weeks and had still not been successful nearly 60 days after his admission. In addition the documentation did not demonstrate that specific requests for consultation on the implementation of an adequate education program for the youth while in D-wing were made by D-wing staff.

The educator indicated she was aware of the youth's recent IEP behavioral component and the need for staff interacting with the youth to be trained in Reactive Attachment Disorder and Post Traumatic Stress Disorder. There is no documentation in the records provided to VP&A indicating that the educator attempted to confirm that D-wing staff interacting with the youth had the necessary training. Many D-wing staff interacting with the youth did not have the requisite training. On September 11, 2006, based in part on recommendations made by an earlier VP&A D-wing report, staff did attend training on trauma sensitivity. This training was provided months after the youth's admission and prior to the use of force that involved the youth's wrist being broken.

The youth's D-wing education plans and the IEP Amendment dated 05/04/06 document the youth's relevant areas of need. However, the education plans for the youth while he was in D-wing did not provide specific educational expectations for these areas or adequately indicate specific actions taken by the educator or other D-wing staff to implement the youth's IEP. Instead the D-wing educational records mostly document on-going problems the youth was experiencing with his education and behavior. The educator's notes include the statement: "The youth has proven time and time again that he cannot handle the education expectations." At one point, the youth's "unwillingness to put an effort into work" apparently resulted in the educator directing staff to place the youth in seclusion. The educator documented that if the youth was unable to comply with her education plan or the consequences such as seclusion he would receive additional point losses and further consequences. On September 5, 2006, the educator documented that she placed additional sanctions on the youth by taking away "all" of his "library privileges until the remainder of his stay" at Woodside. The educator stated that the youth was sanctioned because he was engaging in property destruction and, while the youth was prevented from using the small library maintained by the teachers, he was still given access to other reading materials. This information was not previously documented in the youth's records.

The educator indicated that she monitored the youth's educational services and his behaviors, including when he was secluded in his room due to behaviors in the classroom. However we did not find records demonstrating why the youth was removed from the classroom and secluded on each

occasion that this occurred. The educator could not recall why the youth was removed from the classroom on September 26, 2006, the day his wrist was broken during a restraint. Records indicate that after his wrist was broken the “education plan” for the youth included direction to isolate him in his room during educational time for approximately 15 more days. Between September 5 and October 19, 2006, the educator implemented three week-long “educational plans” for the youth to have his “education in (his) room for duration of plan” with the “door locked.” The October educational plan indicates that the youth was upset and wanted to come out of his room as the educator documented the youth’s “continuous screaming and banging” as he “wanted to come out” once the door to his room was closed. The educator asserts that the youth was only secluded for seven days after his wrist was broken.

The educator also indicated that another teacher in D-wing played a significant role in creating and implementing the youth’s educational plan and provided accommodations to the youth pursuant to his educational needs. VP&A did not interview the other teacher as part of this investigation, in part because there was no documentation in the records provided to us that detailed either the teacher’s level of involvement or the specific accommodations he implemented for the youth. Again, the lack of documentation about what strategies and tactics were employed by D-wing staff to implement an adequate special education program for the youth during his 109 day stay in D-wing is not contested and remains an important concern in our review of the youth’s experience in D-wing.

C Behavioral Management

Records demonstrate consistent identification of troubling and difficult behaviors by D-wing staff without concrete, specific, and informed strategies and tactics to therapeutically respond to them.

On June 28, 2006, staff informed the youth's social worker that "[the youth] is doing okay. He is kind of annoying and needy and has this sense of entitlement..." The records do not indicate that the youth's social worker provided suggestions or offered referrals to D-wing staff regarding how best to address the youth's well-documented "needy" behaviors. In July D-wing staff began documenting several frustrations with the youth. Their records refer to the youth as the "same old [boy]" and "very needy." One staff note documents an apparent attempt at sarcasm stating, "a cow was brought in for his [the youth's] birthday because he milked me dry. [The youth had a] melt down Sunday..."

On July 14, 2006, staff document the youth being secluded that night for "his banging and name calling." On July 20, 2006, the youth spoke with his social worker via telephone. He told his social worker "he was not very well." He reported that he thought he was being sanctioned because he was in a different room and had to "write the book" but felt he had done "absolutely nothing wrong" and that he "doesn't deserve to be there."

On July 21, 2006, records indicate that a Woodside staff member informed the youth's social worker that the youth "is 'terrible' on the unit" and is "constantly" banging, kicking, and swearing for "hours at a time." The staff

member informed the youth's social worker that they have "been trying different tactics to see if they can stop" the youth but that nothing has been successful. The staff member informed the youth's social worker that he was concerned "that if they do restrain him" again that the youth "will continue to escalate in order to be restrained." DCF records document that the social worker told the staff member that restraining the youth again "is a very real possibility as being restrained gives him a sense of being safe."

On August 28, 2006, staff documented that the youth received "correctives on the last shift" and was "pesty over the weekend."

In September 2006, staff documented the youth to be "winey"[sic] and "not great." On September 7, 2006, the youth informed his social worker that he "wants to leave" and "wants to know where he is going." The social worker advised the youth to "focus on doing well at Woodside" while she focuses on finding him a placement. On September 13, 2006, the youth informed his social worker that he was on "an educational plan yesterday for lying to a staff (he said that he didn't lie.)" The records do not indicate that the social worker looked into the youth's complaint of being wrongly accused of lying.

On October 2, 2006, DCF records document the social worker's first contact, via telephone, with the youth after his wrist was broken in the September 26th restraint. The records indicate that the social worker supported the Woodside staff more than the youth as she documented they "talked about the restraint that resulted in *his* breaking his arm." (Emphasis added). She documented that "The youth *was not taking responsibility* for

being out of control and tried to blame everything on other staff...”

(Emphasis added).

The youth’s Case Manager, and the director of the sub-care program at Laraway, confirmed that they had regular contacts with the youth by telephone 4 to 5 times per week and visited the youth once in June. The Case Manager confirmed that she visited the youth in D-wing on July 8th and 26th. Despite the fact that Laraway was part of the youth’s treatment team, neither Laraway staff were informed that the youth had been restrained on July 8th after they visited him.

On July 28, 2006, DCF records indicate that Laraway was fired from the WRAP team due to their allegedly inappropriate interaction with the youth on July 26, 2006. According to Laraway staff they told the youth that he would not be able to contact his foster care parents while he was at D-wing as part of their intervention with him. After their visit with the youth, the Case Manager indicated Woodside staff advocated for the youth by contacting her after the youth had a melt down because he could no longer telephone his foster care parents. The Case Manager stated that a D-wing staff member contacted her because the youth was very upset.

Unfortunately, the phone call to the case worker and the youth’s so-called “melt down” are not described in the youth’s Woodside records.

The Case Manager told VP&A that, prior to July 26, 2006, the youth contacted her almost daily by phone while he was at Woodside, just to chat. The Case Manager stated that the youth would typically call her to talk about food. She indicated that he was obsessed with food and eating. The Case

Manager indicated that the youth looked forward to his calls and interactions with her.

With the exception of the July 26, 2006 termination of Laraway from the youth's "WRAP" team, Laraway staff told VP&A that they thought D-wing staff were doing a good job with the youth. They spoke highly of Woodside staff and indicated that, when they visited the youth on D-wing, it appeared that staff communicated with the youth in the manner appropriate for his developmental age rather than his numerical age. However, the Laraway staff also stated they did not know how D-wing staff obtained information on the youth's disabilities as they did not recall speaking to staff about the youth's behavioral or educational plans.

D-wing staff notes indicate concern over the youth's weight gain and potential gorging behavior while he was there in 2006. DCF case notes documented that the youth's treatment team had similar concerns including the possibility that the youth's medications were contributing to his weight gain. Prior to the youth's admission to Woodside records indicate that at one point he had been taken off his anti-psychotic medication, Risperdal, due to weight gain concerns. Records failed to document the implementation of a comprehensive and medically-appropriate approach to the youth's obsession with food and weight gain issues while the youth was at Woodside in 2006. In one example, the youth complained to his social worker that staff called him a "fat ass" on October 4, 2006. There is no documentation that indicates the social worker, or anyone, investigated this complaint or assessed its implications and impact on the youth.

V Synopsis of Use of Force Episode 1 - July 8, 2006

The July 8, 2006 Incident Report documents that around 1900 hrs the youth was upset with staff after they told him he could not use the bathroom because the bathrooms were full. According to interviews, the youth had a visit with Laraway staff earlier that day. In addition, the youth's medication amount had recently been altered. The Incident Report indicates the youth became upset, destroyed a cup of apple juice, and that staff tried to process with the youth but that the youth was not ready to talk about what had occurred. Staff documented that the youth was "disrespectful" and "noncompliant" but did not describe how the youth was disrespectful or noncompliant. Staff documented that they informed the youth that his behavior was "unacceptable." The Incident Report does not describe how or why his behavior led to staff informing the youth that he earned a zero in the point-based privilege system. Records indicate the youth became even more upset when he learned he received a zero and banged on his door. After 10 minutes of the youth's banging, staff entered his room and tried to process with the youth. Initially, the youth processed with staff "ok" and staff cleaned up the spilled apple juice. Staff documented that the youth was still upset that he received a zero but that the consequence of having a zero would not change. The Incident Report documented that the youth's behavior went up and down as staff attempted to process with the youth, again and again.

The Incident Report indicates that staff entered the youth's room at least four times until he was reportedly so agitated that he began to use his personal belongings to bang on the wall. Staff decided to remove his

belongings from his room. Staff documented that the youth's behaviors escalated into an "attempt to kick."

The Incident Report documented that, after removing his belongings, staff "tried one more time [the fifth time] to process with the youth." Two staff entered his room, made verbal efforts to get the youth to comply with their directions, and when the youth responded by attempting to kick one of them, they restrained him using pain compliance holds and forced him on to the bed frame. The youth was moved in the pain compliance holds to a different room and released. He stated his intention to continue his disruptive behavior in his new room. A team meeting was quickly called and the decision was made to move the youth to the small gym, an area apart from other residents. This was done and the youth was told to stand in the corner of the gym. Initially he complied but, once again, he began verbally threatening staff and moving around when being instructed to stay still. Mechanical restraints were applied. The Incident Report indicates that the youth was held in mechanical restraint "over the next hours+..." while the youth threatened to kill both staff members. The Incident Report does not document the time of day when staff began the restraint nor does it document when it ended. Eventually the Incident Report indicates that the youth agreed to comply "with [staffs'] request to stop threatening [them] and behave himself on the unit." Once the youth agreed "to comply" the mechanical restraints were undone and he was returned to the unit.

Records indicate that the youth immediately complained of injury after this use of force episode but that he was not evaluated by medical personnel until two days after the use of force incident. D-wing policy requires that youth

must be seen by the Woodside nurse, pediatrician or other medical personnel as soon as possible, and no later than the following working day, after the use of force or restraint. The restraint that caused the youth's complaint of injury occurred on a Saturday evening and on Monday July 10, 2006, the nurse documented that she was "asked by staff to [check the youth] post restraint." The youth complained of pain to his thigh and wrist when he was evaluated. Records indicate that the Woodside Director, was made aware of the situation and of the two day wait until the youth was evaluated by medical staff. On July 10, 2006, he documented that "[the nurse] saw the youth this morning" regarding his bruise from the mechanical restraint.

Woodside staff failed to document any specific attempts to de-escalate the youth after he spilled the juice. Instead, records indicate staff contradicted important recommendations from the youth's previous treatment providers on how to address his special needs. There is no documentation indicating D-wing staff took concerns such as using metal cuffs and pain compliance on a child with a severe trauma history and attachment disorder into consideration prior to this episode. Furthermore, it appears the failure to seek outside consultation during the hours leading up to this use of force episode and the failure to provide the youth with a timely medical evaluation appear not to have been considered significant by the D-wing administration review of this event.

Records indicate the youth did not receive any specific therapeutic intervention after the July 8th use of force. His social worker did not record a conversation with him about the incident until July 12th. She noted that the youth was having difficulty with the event as he "wouldn't or couldn't talk

about it” with her. Although records indicate that the social worker tried to assist the youth with his emotions as his therapist suggested, there is no documentation that she asked the youth if he would like to be in contact with the therapist about what had happened to him. The youth’s Laraway case manager stated that she was not informed of the July 8th use of force against the youth.

Between July 8, 2006 and September 26, 2006, staff documented that the youth’s behaviors were getting more “needy.” Staff documented he received “countless time-outs and a zero- [he] takes little responsibility for his own actions. Very poor behavior.” Another staff note documented that the youth did “not [have] a good shift... He had an awful day...” During this time period there is no evidence of any effort to augment or alter the services provided to the youth in D-wing. On September 26th the youth was restrained again.

VI Synopsis of Use of Force Episode 2 - September 26, 2006

D-wing staff notes documented that the youth had an “awful shift” on September 26, 2006. The Incident Report documented that staff used force against the youth after he “was having a very bad day,” being removed from school for noncompliant behavior in the morning and spending much of the day in his room in “an agitated state.” Records indicate the youth was “banging his head and kicking the door” for at least two hours after his removal from the classroom/main room.

Records indicate the youth was quiet for the following 6 hours while in seclusion. He then began to make noises that disrupted the residents who were watching a movie. The Incident Report documented that, during this seventh hour of room seclusion, staff once again tried to calm the youth. When that effort failed, the Incident Report states that staff decided to move him off the unit. While in the process of moving him off the unit the youth continued to be disruptive and was advised that he would be put in restraints if his behavior continued. The youth punched an air pack on the wall and was grabbed by two staff and brought to the floor. Shackles and handcuffs were applied for about two minutes while the youth calmed down and promised to comply. Staff processed this episode with the youth in the hallway for approximately 30 minutes.

The youth was then returned to seclusion and given ice and aspirin in response to his complaint about wrist pain. Records indicate that D-wing staff failed to comply with the medical evaluation aspect of their restraint policy. Woodside medical records indicate that medical staff did not see the youth until September 29, 2006, three days after the use of force incident.

The doctor's medical note, dated September 29, 2006, documented that he was informed on September 27, 2007 that the youth was "injured in a restraint 3 days ago." The medical note documented that he was "called re: whether or not the youth should be seen/x-rayed" and went on to state that "felt it okay to watch for several days given the mechanism of injury and low likelihood of fracture. (No fall- twisted arm during restraint.)" The doctor did not indicate that the person he was relying on for this information was both involved in the restraint that may have caused the injury and was not medically trained. The nurse indicated that she was on vacation during

this time period but did not indicate what nursing coverage was in place during her vacation to provide the requisite medical evaluation of youth involved in restraint. The youth was evaluated three days after the injury on September 29, 2006 and the subsequent x-ray revealed a broken wrist.

The youth's broken wrist was examined and confirmed by a doctor at Fletcher Allen Health Care on September 29, 2006. Fletcher Allen's records document "...a break (fracture) of both bones in the forearm (radius & ulna). The bones are crooked and must be 'set' (reduced) to make them straight again. A splint or cast will be applied which must remain in place until the bone heals (4-6 weeks)." The medical records document that the youth was prescribed Tylenol with Codeine for pain management.

Again, the administrative review of this use of force did not identify and discuss in any meaningful detail the failure of D-wing staff to access outside consultation prior to use of force despite the hours of disruptive behavior or the failure to comply with medical evaluation and treatment requirements. Nor is there any discussion in the administrative review regarding what impact the lack of mental health treatment, specifically trauma therapy, before and after this use of force, may have on the youth.

VII AHS Report on September 26, 2006 Use of Force Episode

The AHS Investigation Unit reviewed and issued a report in response to the September 26th use of force episode. VP&A reviewed the AHS Report and discussed its findings with the lead investigator of the report. The two staff primarily involved in the September use of force episode related important

information to the lead investigator that was not found in any other record of the event, including that the youth was forced onto his stomach, the duration of wrist compressions, that the youth may have stated that he was being hurt by what they were doing to him, and that staff knew they were causing him discomfort. These and other details should have been included in an Incident Report in order to fulfill D-wing policy requirements to describe the event in detail.

Of even more concern is that some of the information supplied to the AHS investigator and omitted from D-wing reports demonstrated inappropriate behavior by D-wing staff. A D-wing staff member failed to detail in his Incident Report that during his last effort to “process” the situation with the youth his communication with the youth included advising him that “when you’re acting like a fucking idiot it bothers me.” While the D-wing staff member acknowledged to the AHS investigator that such a comment was “unprofessional” and “inappropriate,” VP&A is concerned that this exchange was only documented as the result of a special investigation into the youth’s wrist being broken. Both the D-wing records and the AHS Report demonstrate that the youth’s behaviors deteriorated after the D-Wing staff member’s interventions. The AHS investigative report did not consider the impact of the lack of mental health and special education supports provided to the youth while at D-wing prior to the use of force episode.

VIII Observations and Conclusions

While at D-wing in the Summer and Fall of 2006, all of the youth's special needs and required care were or should have been known to D-wing staff. Records document that D-wing staff knew the youth was possibly going to be held at Woodside for several months; this fact contradicts any assertion by D-wing staff that the short-term nature of the detention unit somehow shielded them from an obligation to provide necessary services and accommodations for the youth. VP&A's investigation disclosed that no comprehensive, informed or consistent effort was made by D-wing staff to accommodate the youth's disabilities and special needs while he was detained for 109 days in D-wing. D-wing staff apparently disregarded important information it had or should have had about the youth when imposing sanctions against the youth for behaviors that were directly related to his disabilities.

A Education

None of the records provided to VP&A demonstrated effective implementation of the youth's IEP, including accommodations and therapeutic services determined necessary for him. The lack of documentation and our interview with the educator indicates that there was a failure to comply with Woodside's Special Education Procedures. There was no documented effort to request consultation with service providers in an effort to develop an effective plan to implement his IEP and provide for his special needs while he was in D-wing. There are no records that indicate the educator or any staff consulted with the youth's social worker, therapist, or others regarding the "educational plan" to seclude the youth in his room and require him to complete school work after he was injured as a result of

being restrained. There was no documentation provided that demonstrated any specific strategies or tactics that were adopted to respond to the identified educational problems the youth experienced. It appears that the youth was denied the benefits of his IEP while detained in D-wing over a 109 day period. It also appears that in 2006 D-wing administration, DCF, and even AHS were not motivated to identify or address the systemic failure to provide special education services as this issue was not raised in any of the reports or reviews of the youth's time in D-wing.

B Medical Treatment

In addressing concerns about the youth's medical treatment while at D-wing, VP&A does not intend to criticize the professional medical judgment employed by D-wing medical staff or consultants regarding their decisions to change or eliminate the youth's medications. Rather, our investigation demonstrates that documentation of the decision-making process and of the monitoring and consultation that should go along with providing adequate medical care was lacking in the youth's case. The intent and expectation of issuing this investigative report, including the sections on the youth's medical treatment, is that this information will help assure that appropriate medical care is being provided to youth with disabilities at D-wing in the future, a goal we share with everyone involved in providing these important services to children like the youth detained in D-wing.

The doctor has disagreed with VP&A opinions regarding the youth's treatment at D-Wing but has commented that it was significant that the youth had "multiple exaggerated complaints on almost a daily basis." VP&A

is concerned that the medical records do not document adequately this concern by health care providers nor was there any documentation of a plan to respond to this behavior, despite it being of concern to the doctor. This lack of adequate documentation is at the center of VP&A's concerns based on our investigation regarding the youth's treatment. The doctor has identified that his documentation regarding the monitoring of the effects on the youth from the medication change should have been more comprehensive and he has taken appropriate steps to rectify the inadequacies of documentation apparent in this particular case.

VP&A was provided with no documentation that indicates that Woodside consulted with the youth's previous psychiatrists when administering or changing his medications. Nor was there adequate documentation regarding the impact on the youth's behavior from the changes in his medications. The only medical notes relating to the youth's response to these medication changes appear to be five nursing log notes in the first two weeks of his admission, none in the third week, and then once a week for several weeks. These notes are not rich in detail. The nurse is clearly in a position to interact with all the residents during her work days in the facility as the facility is a small one. This opportunity for interaction is one of the strengths of the D-wing program. However, the behaviors associated with changes in the youth's medication that the nurse may have witnessed were infrequently documented in records reviewed by VP&A.

D-wing medical staff did not adequately document their knowledge of or concern about the youth's weight gain problems. There are no records that indicate that Woodside staff was made aware of the potential relationship of

his medications to the youth's weight problems. Despite weight gain having been an important medical concern for the youth while outside of D-wing, D-wing staff failed to document communication of their concerns about the youth's weight gain to their in-house pediatrician or to the youth's treatment team. The nurse indicated that the "Woodside Programs have been addressing meal planning, low calorie options, fewer fried foods and healthy snack options with our cooks over the past several years. Also UVM medical students have been working with us to implement dietary and activity changes." Yet, there is no specific documentation around these nutrition concerns in the youth's medical records. The lack of documentation regarding how D-wing staff approached the youth's weight gain issues is especially troubling given the youth's history and sensitivity around being deprived of food.

During VP&A's interview with the nurse she indicated that it was not solely her responsibility, but rather that of other Woodside staff and the youth's social worker, to discuss or to request additional information on the youth that may have helped in developing an understanding of necessary or appropriate accommodations for the youth while in D-wing. The nurse indicated that the youth's social worker did not specifically bring any evaluations or plans for the youth's treatment to her attention. She also indicated that, because the youth's behaviors were not considered to be extreme, she did not document efforts to obtain additional outside information about him. The nurse indicated it was common to hear banging and yelling in youths' rooms, therefore she did not consider the youth's behaviors to be unique. She recalled that the youth was secluded in his room on a regular basis. She documented approximately thirteen specific

interactions with the youth between July 6th and October 3rd 2006, roughly one note for each week the youth was detained. The nurse reiterated a common assertion among D-wing staff that, because they are designed to be a short-term detention facility, they are not obliged to focus on disability or trauma issues, only on behavior and security issues.

C July 8, 2006 and September 26, 2006 Use of Force Episodes

In both reported use of force incidents, the youth's disruptive behaviors appeared to be exacerbated by staff's efforts to "process" the situation with him. Due to inadequate documentation VP&A is left to speculate what exactly staff's plan or training was regarding "processing" with the youth. Their efforts appear to directly contradict the outside professional recommendations available to them. Instead, Woodside staff implemented their own plan by removing him from school, secluding him in his room, and pressuring the youth to process while in crisis. The behavioral consultant's plan recommended having an adult in his room without talking with the youth and the therapist's recommendation was to calm the youth down first rather than process with him.

There was no evidence that D-wing staff were encouraged to or attempted to contact their in-house pediatrician or psychiatrist to consult on responding to the youth's behaviors, either during the hours of confrontation that occurred in both episodes prior to the use of force or after those episodes to plan for the next outburst. Nor was there evidence produced demonstrating that D-wing staff made specific efforts to contact the youth's social worker or most recent trauma therapist to provide a comprehensive and informed response

to the youth and the episodes of restraint. No records indicate that staff adequately addressed the youth's mental health and other special needs when the youth exhibited concerning behaviors.

In both use of force episodes there was a delay in providing him with appropriate medical evaluations and/or treatment. VP&A does not support the D-wing policy that allowed for the weekend to pass before a youth complaining of injury as the result of a use of force by staff would be seen by medical staff. VP&A does not support this policy as it conflicts with the twenty-four hour a day, seven day a week nature of the detention program. Delaying medical evaluation and care over the weekend can and did cause additional harm and stress to this youth who had been the subject of painful use of force episodes.

Woodside staff failed to follow Woodside policies with respect to providing the youth with medical care in the more serious September 26th use of force incident. Although D-wing staff did contact the pediatrician the morning after the September 26th use of force incident, the doctor consulted with the staff person over the phone instead of evaluating the youth's wrist in person. This decision was due in part to the fact that the doctor is only contracted for four hours of service a week at the facility although he makes himself voluntarily available by phone seven days a week. The doctor relied on non-medically trained staff at D-wing when assessing the need to have the youth taken for actual medical evaluation at the emergency room. The non-medical staff that the doctor relied on was directly involved in the restraint that was apparently the cause of the injury. Based on this telephone call, the decision was made not to have the youth evaluated by medical staff until three days

after the incident when the doctor would be back in the facility. The fact that the youth endured pain from an undiagnosed broken wrist for days added another traumatic event from which the youth must recover. It does not appear that the youth was informed that policy had been violated in this instance or that his custodians were concerned that he suffered unduly from this policy violation.

Woodside's restraint policy was updated in June 2006 to require that each staff member involved in or witnessing a restraint must complete an incident report describing the situation in detail. VP&A's review of the July and September Incident Reports indicate that Woodside staff failed to comply with this policy. Not every staff member involved completed a report. Critical information was omitted from the Incident Reports that were created. These omissions were identified but not emphasized in the Agency of Human Services investigative report (AHS Report) on the September 26th use of force incident.

D DCF Involvement

VP&A's investigation demonstrated that the youth's social worker did not make sufficient efforts to notify D-wing staff about special considerations and requirements relating to a therapeutic response to the youth's difficult behaviors. There is no evidence that the youth's social worker made efforts to raise concerns with D-wing staff about implementation of his IEP or other recommendations of the various evaluations and plans that had been developed prior to this D-wing placement. Rather than providing advice on how to address the youth's behaviors or ways to prevent Woodside staff

from restraining the youth, the social worker failed to mention to the D-Wing staff the recommendations contained in the Trauma Evaluation or behavioral plan by the behavioral consultant. Unfortunately the social worker's statement to a D-Wing staff member about restraints giving the youth a "sense of being safe" directly contradicts the therapist's consultation meeting when he informed the youth's treatment team that restraints take an emotional toll that inflicts secondary trauma on the youth. Clearly her focus was on finding a placement outside D-wing as soon as possible, but that left the youth without a key advocate regarding his current needs while detained at Woodside.

There appear to be several areas where DCF failed to provide therapeutic services to the youth while he was at Woodside as demonstrated when DCF terminated the youth's contact with Laraway. DCF's termination of Laraway from the youth's "WRAP" team and of the case worker's contact with the youth should have raised concerns in light of the youth's history of difficulty forming relationships and attachments. Records indicate that neither the youth nor the Case Manager was given an opportunity to discuss why their relationship had been terminated. The therapist indicated that closure for the youth, i.e. termination of his relationship with the case worker, would have been a good idea for him.

Records and interviews indicate that the youth's social worker failed to investigate the youth's complaints against D-wing staff and allegations of mistreatment and failed to contact his therapist after the restraint and wrist injury.

E AHS Investigation

The Agency of Human Services' investigation into the circumstances surrounding the broken wrist incident, similarly to D-wing's own internal review, failed to accurately identify areas of concern and resolve questions related to the appropriateness of staff's responses to the youth's behaviors.

IX Recommendations

VP&A recommends that Woodside take the following actions:

- A Provide the youth a written apology for the harm he suffered while in D-wing due to failure of DCF and D-wing staff to follow policies and to provide adequate mental health and medical treatment, special education services, trauma informed services and effective oversight of his stay there;

- B Provide a written plan with timelines to implement new procedures to assure the:
 - (1) assessment of disabilities;
 - (2) the provision of reasonable accommodations;
 - (3) continuing, individualized and effective mental health treatment and special education services to detainees legally entitled to them;
 - (4) immediate prohibition of use of pain compliance;

- (5) adequate oversight of the use of force and provision of legally required services such as mental health, medical and special education services;
- (6) creation of a staff position responsible for identifying special needs/accommodations and services for new detainees at D-wing and for assuring the required accommodations and services are provided in an integrated and effective manner.

VP&A welcomes comments regarding this report. Please send comments to Ed Paquin, Executive Director, Vermont Protection and Advocacy, Inc., 141 Main Street, Suite 7, Montpelier, Vermont 05602, or to info@vtpa.org.