STATE OF NEW HAMPSHIRE

HILLSBOROUGH NORTH, *ss.* SUPERIOR COURT

CASE NO. 216-2021-CR-00746

STATE OF NEW HAMPSHIRE,
DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.

v.

BRADLEY ASBURY

PARTIAL VICTIM IMPACT STATEMENT PURSUANT TO RSA 21-M:8-K

Michael Gilpatrick, the victim of the May 1998 gang rape orchestrated by the defendant, Bradley Asbury, in this case, states as follows:

1. I have a "right to appear and make a written or oral victim impact statement," and otherwise be "treated with fairness and respect" in this matter, pursuant to RSA 21-M:8-K. I wish to make part of my statement now and the rest while physically at the sentencing, scheduled for January 27, 2025 at 10:00 A.M.

2. I have received and reviewed Asbury's sentencing memorandum in which he seeks to avoid full accountability for his crimes. He attached several letters and documents stating that he is no longer young, that he was a basketball coach and that some people like him, as reasons to mitigate his sentence for organizing and participating in the gang rape against me.

3. In the interest of completeness, I attach an additional letter and an additional document that was not included and with which the Court may be unfamiliar, but which serves to help round out the portrait of the defendant to aid the Court in sentencing.

4. **Exhibit A** is a letter dated July 18, 1994, from Lorrie L. Lutz, then the Director of the Division for Children, Youth and Families, terminating Asbury immediately from his position

as leader of the NH Youth Detention Services Unit (YDSU) "for willful misuse of your supervisory position" at the child residential center. Among other findings, Director Lutz found that Asbury had "threaten[ed] the safety of the residents and staff" by various conduct, including:

- demonstrating "a callous disregard for the rights of residents"
- violating his obligation under the Code of Ethics "to protect the rights of the youth we serve"
- willfully falsifying agency records
- "creat[ing] an environment which is hostile and threatening to residents thereby threatening the safety of residents"
- "seriously jeopardiz[ing] the safety and well-being of residents

5. The letter from Director Lutz concludes as follows:

> You have repeatedly engaged in behavior that willfully misuses your supervisory position and constitutes dereliction of duties and is largely responsible for the hostile environment and substantial divisions that exist at YDSU.
>
> In addition, you have failed in your responsibility as a supervisor to provide a safe, healthy, and therapeutic environment for the residents. The seriousness of your actions compel me to terminate you from your position effective immediately.
>
> **Exhibit A** (Emphasis added).

6. **Exhibit B** is a report of an investigation by DHHS and DCYF into misconduct by Asbury and others dated July 8, 1994. Among other findings, the report concludes that staff could not report mistreatment of children at the facility to Asbury because "either he was involved or modeled the mistreatment in question" or the staff "feared retaliation" from Asbury for reporting misconduct. Ultimately, the report concluded that "Asbury has been derelict in the discharge of his supervisory responsibilities… Asbury should be terminated."

7. Exhibit A and B date from 1994. At some point thereafter, the State rehired Asbury and made him the leader at East Cottage at YDC, without supervision or remedial training, where he controlled all the staff and held the lives of the residents in his hands. That included me when I arrived there in 1997, and also me, when he orchestrated and supervised the gang rape of me in May 1998, for which he has been convicted and now faces sentencing. The gang rape was nearly four (4) years after the State knew he was a grave danger to children and "seriously jeopardized the safety and well-being of residents." *See* **Exhibit A**.

8. Exhibits A and B were kept secret from the public (and from me) by the State for 30 years until my counsel forced their disclosure in late 2023 in discovery in the civil case brought by David Meehan, which went to trial last year and resulted in a jury finding that the State breached its fiduciary duty by wanton and malicious conduct. That jury believed David Meehan, just as the Asbury jury believed me. In both cases, Brad Asbury was the direct supervisor and ringleader of the rapists who brutalized vulnerable, traumatized, emotionally-disabled boys from dysfunctional homes who were placed in state custody for therapeutic and rehabilitative purposes. In my mind, there are few human acts more evil and blameworthy than what he did, or more deserving of a strong sentence to deter others who might be tempted to ever do likewise.

Respectfully submitted,

MICHAEL GILPATRICK

By and through counsel,

Dated: January 22, 2025

RILEE & ASSOCIATES, P.L.L.C.

/s/ Cyrus F. Rilee, III
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CERTIFICATE OF SERVICE

I certify that on January 22, 2025 I am sending a copy of this document as required by the rules of the court. I am electronically sending this document through the court's e-filing system to all attorneys and to all other parties who have entered electronic service contacts (email addresses) in this case.

/s/ David A. Vicinanzo

EXHIBIT A

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION FOR CHILDREN, YOUTH AND FAMILIES
6 Hazen Drive Concord, NH 03301-6522 TDD Access: Relay NH 1-800-735-2964 FAX: 603-271-4729

Harry H. Bird, M.D., Commissioner
Lorrie L. Lutz, Director
603-271-4451

July 18, 1994

Bradley Asbury, House Leader II
Youth Detention Services Unit
Youth Services Center
Division for Children, Youth and Families
Department of Health and Human Services
45 South Fruit Street
Concord, New Hampshire 03301

Re: Letter of Dismissal Without Prior Warning

Dear Mr. Asbury:

Pursuant to PER 1001.08(b)(8) of the Rules and Regulations of the Division of Personnel, this letter is written to notify you of your immediate termination from employment effective Monday, July 18, 1994 under the dismissal without prior warning rules for willful misuse of your supervisory position.

At the request of the Director of the Division for Children, Youth and Families ("DCYF") and with the authorization of the Office of the Attorney General pursuant to RSA 169-C:37, an investigation of serious allegations of mistreatment of resident at staff at the Youth Detention Services Unit ("YDSU") of the Youth Services Center ("YSC") was conducted. The investigators directly interviewed 39 present and former staff of YDSU in 42 meetings totalling more than 70 hours. In addition, one person was interviewed by telephone. The investigators did not interview past or present residents of the facility. With one exception, all individuals were interviewed by both investigators together and were asked similar questions. If the investigators were aware of specific allegations about an interviewee, the interview was informed of these allegations (without reference to the source) and given an opportunity to respond. The investigators also reviewed YSC Policies, YDSU documents such as restraint and restriction reports, supervisory logs and reports, incident reports and resident records, and employee personnel files. The conclusion of the investigation substantiated abuse of YDSU residents, violation of YSC policies, mistreatment of YDSU staff and willful misuse of supervisory position.

The disciplinary actions imposed upon you has been taken because allegations were substantiated by the investigators by credible accounts of verifiable incidents, YDSU records and by statements you made to the investigators during the interview process. In your case the following was noted by the investigators:

1. The Supplemental Job Description for your position (House Leader II) states that you are "To provide leadership, supervision and direction to staff and residents..." Your duties include "assists in the development and is responsible for the implementation of program policy procedures applicable to the residential component; and, provides leadership for staff and residents and demonstrates the ability to provide positive role modeling through job performance and interpersonal skills." A copy of the Supplemental Job Description is attached as Exhibit A hereto.

2. The Youth Detention Services Unit is a 24 hour/day, 7 day/week facility providing physically secure care to youth ordered detained by the courts. Pursuant to your Supplemental Job Description, as House Leader II you are responsible for the operation of the dormitory facility at YDSU. This responsibility includes establishing schedules for the approximately twenty (20) youth counselors that work at the dormitory, approving requests for time off and other leave, establishing staffing patterns for the dormitory, and controlling the hiring and promotion of dormitory staff.

3. The Youth Services Center Code of Ethics ("Code of Ethics"), a copy of which is attached as Exhibit B hereto, states in relevant part that employees are responsible for understanding all YSC policies, procedures and regulations. The Code of Ethics contains a number of explicit prohibitions including "Employees shall not use their official position to secure privileges for themselves or others."

4. The following conduct have been substantiated as a result of the investigation. Each of these actions constitutes willful misuse of your supervisory position.

a) In December, 1993 you held a meeting in your office, which is located on the dormitory, with Paul Nugent, Patrick Kenney and Vincent Urban. During the course of that meeting, by your own testimony as well as the testimony by others present, you swore at and physically threatened a colleague. You described your conduct at this meeting to the investigators as very unprofessional. Such interaction with staff is an example of your failure to model appropriate behavior for resident and staff and your mistreatment of staff.

b) As described to the investigators by staff members, your meetings with staff members at times resulted in heated exchanges during which you yelled and sometimes swore at staff. One staff member described these encounters as "incredible headbutts". During your interview with the investigators you described your interactions with your own supervisor as often being in disagreement and that some of these disagreements were loud. These various meetings often occurred in your office which is located on the residents' dormitory. A number of staff (and it is presumed residents) overheard these interactions. You justified such behavior to the investigators by indicating that it only occurred "behind closed doors". Such interactions with staff are examples of your failure to model appropriate behavior for residents and staff and your mistreatment of staff.

c) Your Supplemental Job Description provides that you are to "evaluate[s] staff work performances and schedule[s] youth counselors in an effort to provide optimal shift coverage". Pursuant to your authority to create dormitory schedules and assign staff, you assigned your stepsons to the same night shift, where one stepson is the shift supervisor and the other stepson is one of the two subordinate youth counselors assigned to the shift. As stated by your stepsons, this staff assignment accommodates their personal schedules. This staff assignment also renders effective supervision of the shift difficult and creates a perception of favoritism. This staff assignment has also created instability within the shift because a number of female staff assigned to the shift stated to the investigators that the climate created by working only with the stepsons of the House Leader was difficult.

d) [redacted]

[redacted]

e. You failed to maintain an appropriate division between your personal life and your professional responsibilities as supervisor of the dormitory staff. You regularly engaged in recreational activities with a number of subordinates, and developed close personal friendships with a number of subordinates. This failure to maintain an appropriate distance between your personal life and your professional life has resulted in your ineffective supervision of those subordinates that are your friends and the pervasive perception of favoritism and unfairness that exists within YDSU.

5. The Code of Ethics states that YSC is dedicated to serving youth by providing residential care, and education in a safe and healthy environment to youth who have been identified by the courts... to be in need of the services provided at the Youth Services Center. The YSC policy entitled "Ombudsman System", a copy of which is attached as Exhibit C, requires a resident shall be given a form on request and that when its completed, the form shall be "mailed/delivered" to the Ombudsman. A number of staff stated that you subverted the Ombudsman process in a number of ways including tearing up forms completed by residents, requiring residents to speak directly with staff involved in the incident prior to receiving a form, and making disparaging comments about the Ombudsman process and the residents' likelihood of success. Such conduct demonstrates a callous disregard for the rights of residents, violates your obligation under the Code of Ethics "to protect the rights of the youth we serve" and constitutes a willful misuse of your supervisory position. You have also by these actions engaged in willful falsification of agency records. You have created an environment which is hostile and threatening to residents thereby threatening the safety of residents and staff. Your actions have resulted in the disruption of agency services as residents were unable to effectively utilize the Ombudsman process to seek redress for alleged abuse or neglect at YDSU.

6. The rules relative to the various levels of restriction to be employed by staff as part of the behavior management program at YDSU were clearly delineated by policy and in the YDSU Staff

Handbook. Also clearly articulated in these documents was the chain of command to authorize the use of restrictions. However, direct care staff provided varied and conflicting information to the investigators relative to the hierarchy of authorization for the use of restriction. Further, although the rules governing chair restrictions were established by written policy, the investigators found there to be little consistency in staff implementation of such policies. For example, a number of Youth Counselors (levels I and II) felt that they could give a 4-hour restriction without supervisory approval. There was also inconsistency among staff on the issue of who could authorize longer restrictions (up to 24 hours). The fact that the basic rules of the cornerstone of the resident management program then in place at YDSU were not uniformly understood is your failure. Your lack of leadership to provide supervision and training on YDSU training and rules seriously jeopardized the safety and well-being of residents.

You have repeatedly engaged in behavior that willfully misuses your supervisory position and constitutes dereliction of duties and is largely responsible for the hostile environment and substantial divisions that exist at YDSU. In addition, you have failed in your responsibility as a supervisor to provide a safe, healthy and therapeutic environment for the residents. The seriousness of your actions compel me to terminate you from your position effectively immediately. You are to turn in any property of the Department of Health and Human Services in your possession, including without limitation, identification and keys, to me or my designee immediately.

The rules of the Division of Personnel require that you acknowledge receipt of this letter of dismissal without prior warning. Please sign the acknowledgement of receipt on the line below. A copy of this letter shall be placed in your personnel file both here and in the central files at the Division of Personnel.

In accordance with the Rules and Regulations of the Division of Personnel, you have fifteen (15) calendar days to appeal this notification of severe warning with option for dismissal to the Personnel Appeals Board under the Provisions of RSA-21-I:58. If such action is not taken, it will be assumed that you acknowledge this termination as justified.

Sincerely,

Lorrie L. Lutz, Director
Division for Children, Youth and Families

Refusal to sign - understands it does not change the termination

I hereby acknowledge receipt of this letter of dismissal without prior warning. My signature does not express my agreement or disagreement with the contents of this letter.

Attachments

cc: Virginia Lamberton, Director
NH Division of Personnel

Sandra Platt, Director
division of Human Resources
NH Department of Health and Human Services

EXHIBIT B

TO: Dana Bisbee
Deputy Attorney
General

FROM: Ryan Long
DCYF

NEW HAMPSHIRE DEPARTMENT OF HEALTH AND HUMAN SERVICES

MESSAGE

SUBJECT: Detention Unit
Investigation-YDC

Dear Dana

Enclosed is a photocopy of the report by Tricia Lucas and Mary Lou Sudders as to their investigation this past summer of Youth Services Center

DATE 10/6/95 SIGNED Ryan Long

TO: Dana Bisbee
Deputy Attorney General

FROM: Rogers Lucas
DCYF

NEW HAMPSHIRE DEPARTMENT OF HEALTH AND HUMAN SERVICES

MESSAGE

SUBJECT: Detention Unit Investigation-YSC

Dear Dana

Enclosed is a photocopy of the report by Travis Lucas and Mary Lou Sudders as to their investigation this past summer of Youth Services Center

DATE 1/6/95 SIGNED Rogers Lucas

STATE OF NH
DEPT OF JUSTICE
95 JAN -6 PM 2:08

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MENTAL HEALTH AND
DEVELOPMENTAL SERVICES

Harry H. Bird, M.D.
Commissioner
Department of Health and Human Services

Donald L. Shumway
Director
Division of Mental Health and
Developmental Services
105 Pleasant Street
State Office Park South
Concord, NH 03301
603/271-5000

271-5007

July 20, 1994

TO: Daniel J. Mullen, Chief of Staff
Office of the Attorney General

Lorrie L. Lutz, Director
Division for Children, Youth and Families

FROM: Marylou Sudders, Deputy Director
Division of Mental Health and Developmental Services

Tricia Lucas, General Counsel
Division for Children, Youth and Families

RE: Investigation of Allegations of Staff and Resident Mistreatment
at the Youth Detention Services Unit

THIS REPORT WAS PREPARED AT THE REQUEST OF AND WITH THE AUTHORIZATION OF THE OFFICE OF THE ATTORNEY GENERAL TO AID IN THE FULFILLMENT OF ITS RESPONSIBILITIES UNDER RSA 169-C:37 AND IN CONTEMPLATION OF POSSIBLE LITIGATION AND IS THEREFORE PROTECTED WORK PRODUCT AS WELL AS SUBJECT TO ATTORNEY CLIENT PRIVILEGE.

Attached please find an Addendum to the Investigation Report on the above referenced subject dated 8 July 94. This Addendum is to be considered part of the official document and should be inserted prior to Appendix A.

This Addendum adds an additional paragraph to the Overview (to be inserted after paragraph three), clarifies Findings 7, 18, 19, 28, 49 and 58, and adds two additional sentences to Observation 3 of the Conclusion.

This document in addition to the Investigation Report dated 8 July 1994 constitutes our full report investigating allegations of staff and resident mistreatment at the Youth Detention Services Unit.

MLS:TL:mry

July 20, 1994

INVESTIGATION OF ALLEGATIONS OF STAFF AND RESIDENT MISTREATMENT AT THE YOUTH DETENTION SERVICES UNIT: AN ADDENDUM TO THE ORIGINAL INVESTIGATION

This addendum adds material to the Overview and to Observation 3 in the Conclusion and clarifies Findings 7, 18, 19, 28, 49 and 58 of the report dated 8 July 1994. This addendum in addition to the report dated 8 July 1994 constitutes the full investigation of allegations of staff and resident mistreatment at the Youth Detention Services Unit (YDSU).

OVERVIEW

The following paragraph is to be inserted between paragraphs three and four in the Overview section of the report.

In addition to conducting the interviews described in the preceding paragraph, the investigators reviewed the written policies of the Youth Services Center, the staff and resident handbooks, more than twenty (20) resident records, staff personnel files and a variety of other documents from YDSU. The other documents reviewed were: incident reports; disciplinary reports; restriction logs; supervisory logs and reports; and, the dormitory communication log.

FINDINGS

The following statements are to be added to Findings 7, 18, 19, 28, 49 and 58. These findings in concert with the Findings dated 8 July 1994 constitute the official report.

Finding 7: [redacted]

Finding 18: [redacted]

Finding 19: [redacted]

Finding 28: [redacted]

Finding 49: It has been substantiated elsewhere, however, that Mr. Asbury has used profanity in speaking with staff (refer to Recommendation No. 3).

Finding 58: Further, the investigators found that Mr. Nugent's actions were warranted given the recommendation by the promotion board. In this matter, Mr. Nugent interviewed three members and affirmed the original decision.

CONCLUSION

The following sentences are to be inserted at the end of Observation 3 in the Conclusion section of the report.

We note that no disciplinary action was recommended for John Sheridan, Administrator of the Bureau of Residential Services. Mr. Sheridan indicated his decision to retire from his position prior to the commencement of the investigation and provided a letter of resignation to the Director. Further, the investigators received no specific allegations concerning Mr. Sheridan's conduct at YDSU.

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MENTAL HEALTH AND
DEVELOPMENTAL SERVICES

Harry H. Bird, M.D.
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Department of Health and Human Services

Donald L. Shumway
Director
Division of Mental Health and
Developmental Services
105 Pleasant Street
State Office Park South
Concord, NH 03301
603/271-5000

July 8, 1994

To: Daniel J. Mullen, Chief of Staff
Office of the Attorney General

Lorrie L. Lutz, Director
Division for Children, Youth and Families

From: Marylou Sudders, Deputy Director
Division of Mental Health and Developmental Services

Tricia Lucas, General Counsel
Division for Children, Youth and Families

Re: Investigation of Allegations of Staff and Resident Mistreatment at the Youth Detention Services Unit

THIS REPORT WAS PREPARED AT THE REQUEST OF AND WITH THE AUTHORIZATION OF THE OFFICE OF THE ATTORNEY GENERAL TO AID IN THE FULFILLMENT OF ITS RESPONSIBILITIES UNDER RSA 169-C:37 AND IN CONTEMPLATION OF POSSIBLE LITIGATION AND IS THEREFORE PROTECTED WORK PRODUCT AS WELL AS SUBJECT TO ATTORNEY CLIENT PRIVILEGE.

Attached please find our report investigating allegations of staff and resident mistreatment at the Youth Detention Services Unit (YDSU). During the course of our investigation, we conducted more than seventy (70) hours of interviews with thirty-nine (39) former and current staff, read more than twenty (20) case files, and reviewed a panoply of related documents. Seventy-one (71) allegations were investigated and findings made.

A number of allegations regarding the treatment of residents and staff in addition to the existence of a hostile work environment are substantiated. Observations and recommendations for corrective action, including possible personnel actions, are also included in the report. Attached to the report are copies of relevant YDSU policies and excerpts from a number of resident records to which references are made in the report.

OVERVIEW

On 31 May, 1994, Lorrie Lutz, Director for the Division of Children, Youth and Families (DCYF) was made aware of allegations of child and staff mistreatment and management failures at the Youth Detention Services Unit (YDSU or "facility"). These allegations were initially raised by a current staff member at YDSU, Lora Reynolds, Youth Counselor II. A subsequent meeting held on 4 June 1994 was attended by Ms. Lutz, Health and Human Services, Human Resources Coordinator Sandra Platt, and sixteen (16) current and former staff; this meeting yielded additional allegations and concerns by attendees about retaliation by supervisory staff. Written statements concerning the allegations were solicited by Ms. Lutz and eleven (11) statements were subsequently submitted.

On 6 June 1994, Ms. Lutz took immediate action to intercede at the facility regarding the use of chair restriction, personnel actions, and the filing of child complaints (Ombudsman reports). On 10 June 1994, Marylou Sudders, Deputy Director of the Division of Mental Health and Developmental Services (DMHDS) and Tricia Lucas, General Counsel of DCYF were appointed by Ms. Lutz with the approval of the Office of the Attorney General to investigate the allegations. A brief chronology of events is attached as Appendix A.

During the course of the investigation, the investigators became aware of additional allegations. These allegations were investigated in addition to the specific allegations contained in the written statements. The investigators directly interviewed 39 present and former staff in 42 meetings totaling more than 70 hours. In addition, one person was interviewed over the telephone. The investigators did not interview past or present residents of the facility. Interviewees represented all employee classification titles and levels relative to YDSU, including management and supervisory staff, direct care workers, support staff, teachers and nurses. The investigators interviewed current and former, full-time as well as part-time staff. A listing of interviewees by title and employment status is contained as Attachment B. All individuals were interviewed by both investigators together and were asked similar questions. If the investigators were aware of specific allegations about an interviewee, the interviewee was informed of these allegations (without reference to the source) and given an opportunity to respond.

As an overall statement, there is no evidence to substantiate systemic abuse of youth at the facility now that the excessive use of chair restriction and room confinement have been abolished. However, there are substantiated incidents of both staff and youth mistreatment which will be delineated in detail within this report. Further, there is much evidence to suggest that key YDSU supervisors have engaged in the willful misuse of their positions and have created a hostile work environment [redacted] YDSU suffers from a serious lack of management oversight and the failure of supervisory staff to discharge their professional responsibilities. This void of reasonable, supervisory leadership when combined with poor communication at all levels within the facility has resulted in substantial divisiveness within the facility as well as a pervasive climate of mistrust among the staff. There is minimal collaboration among the three primary work units within the facility (dormitory, teaching and nursing units) and among the management staff. The result is that two of these units (dorm staff and teaching staff) are fragmented both within their units and across the units.

Although nursing is a cohesive unit, it has been isolated from both the teaching staff and dormitory units.

In addition to a review of all allegations made in the written statements and received by the investigators during the course of the interviews, a number of recommendations will be made relative to the overall absence of positive supervisory relationships, lack of management oversight, lack of positive role models for staff and residents, as well as the lack of trust at all levels within the facility.

I. ALLEGATIONS OF MISTREATMENT OF RESIDENTS

Allegations concerning treatment of residents at YDSU fall into the following general categories: (1) [redacted] (2) Verbal Abuse; (3) Physical Abuse; (4) Provocation; (5) Restrictions; (6) Room Confinement; (7) Ombudsmen Procedures; (8) Inappropriate Conversations; and (9) Other. The allegations concerning treatment of residents will be organized by reference to these categories. The source and specific nature of the allegations will be identified. To the extent that findings are applicable to more than one allegation, it is so noted.

A. [redacted]

B. Verbal Abuse: Yelling, swearing at residents, ridicule of residents

Allegation 3: [redacted]

Finding 3:

Allegation 4:

Finding 4:

Allegation 5: "Donna [Fleming] has no respect for the residents or staff. She does not empathize with the youth's situation. She is not a good listener or mentor and in no way has the understanding to counsel them in any way. During my employment I never once heard Donna say a positive word to a resident." (Vicki Chaski) There were numerous references in interviews to Ms. Fleming's lack of empathy and her critical nature (directed both to residents and to staff).

Finding 5: Substantiated. Ms. Fleming's most recent performance evaluation refers to her lack of patience and the need for greater tolerance in working with people. By her own testimony, she acknowledges these shortcomings but believes that her job is not to provide counseling to residents but to ensure that they are compliant. Ms. Fleming also indicates that she thinks the female residents are the most difficult to work with and that she would prefer to work with boys. The vast majority of staff interviewed described Ms. Fleming as disrespectful and hostile to both residents and staff. Ms Fleming's lack of respect for the residents is clearly demonstrated by a number of notations on the daily YDSU shift supervisory reports, which are completed at the end of each shift by the supervisor. Ms. Fleming is the supervisor on the first shift Monday through Friday. Six separate supervisory reports in the last six months have included the following references to residents: Chad [redacted] a small ten-year-old resident for whom a nursing order was written permitting him to have a stuffed animal, was referred to not by name but as "T. Bear" or "the bear"; "We will complete Bill 'Baby Face' [redacted] intake information tomorrow, he was crying too much to do it today," "Ed the chicken hawk finally started to be cooperative today," "The helicopter pilot has been temporarily grounded and has to wear headgear;" and "the junior birdman has flown the coop

at least temporarily." We note that the staff that work directly with Ms. Fleming on her shift (Ida Quinones and Jeff Mills) describe her as a fair supervisor who works hard. Mr. Mills and Ms. Quinones deny that they have ever seen Ms. Fleming verbally abuse or ridicule a resident.

Allegation 6: [redacted]

Finding 6:

Allegation 7:

Finding 7:

Allegation 8: "On June 24, 1993 at 7:30 a.m., Mark [redacted], one of the residents at YDSU, was hauled out of the dining room and put in the time out room by Rich LaBerge and Mike Blake. I could hear Mark yelling, "Get off my back, you are hurting my arm" and I heard Rich LaBerge yell back at him "shut up you little fucker." (Debbie Levesque, Secretary)

Finding 8: Substantiated. The resident's record shows that Mark was restrained on the day in question. Ms. Levesque's office is immediately adjacent to the time-out room. Although she did not see the incident, she was so upset by what she heard that she went first to one staff member and then to Mr. Sheriden to report what she heard. The specificity of her recollection is in contrast to the general nature of Mr. LaBerge's denial ("I don't swear at kids").

Allegation 9: "One morning when we (Mary Roy and residents Jamie [redacted] Angel [redacted], Angela [redacted] April [redacted] and several other female residents) were all in the Level 2 room, Donna Fleming woke up a male resident (who was sleeping in Level 2 room or outside the room while on restriction), who said something to Donna. Donna replied, 'Shut your fucking mouth and get up.' 'The female residents observed that if they had made a comment like that they would have been placed on restriction." (Mary Roy)

Finding 9: Substantiated. Mary Roy, Youth Counselor II confirms her written statement and was a witness to this event.

C. Physical Abuse

Allegation 10: [redacted]

Finding 10:

Allegation 11: [redacted]

Finding 11: [redacted]

Allegation 12: [redacted]

Finding 12: [redacted]

Allegation 13: [redacted]

Finding 13: [redacted]

Allegation 14: "One morning Wes [redacted] refused to get out of bed; he said he was sick. So Rich (LaBerge) went in and kicked and kicked his bed [because he was on suicide precaution, his bedframe had been removed and he was sleeping on a mattress on the floor], telling him he was getting up. When Wes called Rich a name, Rich jumped on him and restrained him. Meantime his sidekick Donna Fleming ran in and jumped on his leg. This kid was not fighting them; all he did was cry and say they were hurting him. After 5 minutes or so they got off and the kid just curled up in a fetal position and cried hysterically." (Vicki Chaski)

Finding 14: Substantiated. Ms. Chaski's account of the incident is credible and she is a direct witness. Ms. Chaski witnessed Mr. LaBerge kicking the mattress that Wes [redacted] was lying on. Rich LaBerge remembers the incident but his recollection is substantially different; the resident was on suicide observation and wouldn't get up saying he was sick. Rich got the nurse on duty who said Wes could get up. At this time Wes began banging his hand against the wall and was restrained. We note that the day after this incident that the resident was involuntarily admitted to the Philbrook Center.

Allegation 15: [redacted]

Finding 15:

Allegation 16

Finding 16:

Allegation 17

Finding 17:

Allegation 18

Finding 18:

Allegation 19:

Finding 19:

Allegation 20:

Finding 20:

Allegation 21: [redacted]

Finding 21: [redacted]

D. Provocation

Allegation 22: [redacted]

Finding 22: [redacted]

Allegation 23: [redacted]

Finding 23: [redacted]

Allegation 24: Allegation concerning provocation of Wes [redacted] by Richard LaBerge. See Allegation 14.

Finding 24: See Finding 14.

Allegation 25: "Rich [LaBerge] loved to provoke residents; an example was Brandon [redacted] who knew he was leaving. So Brandon mouthed off to Rich. Rich slammed him in a chair. Brandon stood up and Rich said "Come on, hit me." Brandon continued to call him names so Rich threw his chair in a room and told him to get in it. As Brandon walked through the door, Rich pushed him into the room. Brandon never once tried to strike Rich. Rich told us afterwards he wished Brandon had hit him because he would have killed him. (Vicki Chaski)

Finding 25: Substantiated. Ms. Chaski is a direct witness and presents a credible account of the event.

Allegation 26: Rich LaBerge provoked resident Gerry [redacted] into a restriction. (This allegation comes from our review of the progress note in Gerry's file for December 8, 1993 written by Rich LaBerge). A copy of the progress note in question is attached to this report.

Finding 26: Substantiated. The progress note written by Rich LaBerge speaks for itself. When Mr. LaBerge was asked about it during his interview he acknowledged that it looked like he had provoked the resident.

Allegation 27: "I have seen Rich LaBerge antagonize a resident until the resident is pushed to the limit and goes off. One morning while Jason [redacted] was at YDSU, Rich called him into the office to speak with him about his behavior. While Rich spoke with him,

he was pointing his finger at him, Jason told him to get out of his face and stop pointing at him. Rich became upset with this and told Jason that he would stay in his face and point his finger at him all he wanted and proceeded to point his finger into Jason's chest". (Mary Roy)

Finding 27: Substantiated. Mary Roy was a direct witness to the confrontation. We note that the office has a plexiglass window in the door.

Allegation 28: [redacted]

Finding 28: [redacted]

E. Restriction (Chair restriction in lobby and room restriction; chair in doorway of the room while the door to the room was open)

[redacted]

F. Room Confinement

Room confinement is the placement of a youth in his/her room with the door locked and is to be distinguished from "room restriction" where the resident sits at a desk in the open doorway of the room. Existing policy describes the proper use of room confinement: "Room confinement is used as a short period in which a juvenile can stabilize his/her behavior or as a restriction when necessary to ensure the resident safety or facility security." Room confinement requires the authorization by the YDSU supervisor.

Allegation 29: [redacted]

Finding 29: [redacted]

[redacted]

Allegation 30: Resident Jennifer [redacted] was confined in her room from 8:55 p.m. Friday, May 20, 1994 until approximately 7:00 a.m. on Monday, May 23. Such room confinement constitutes abuse of the resident.

Finding 30: Substantiated. Jennifer [redacted] had one previous stay at YDSU and had been described during that stay as compliant. In May, 1994, she was ordered by the Court directly to shelter care; she was not administratively transferred from YDSU to the shelter care. She was admitted subsequently to YDSU from the shelter following an AWOL from the shelter. According to the shift supervisor's notes on May 20, 1994, Jennifer arrived at YDSU and was, pursuant to the unwritten policy concerning residents who are returned from shelters, assigned a 24-hour restriction. (Normally this restriction is served in a chair in the open doorway of the resident's room.) This unwritten policy requires that the restriction be approved by Mr. Nugent. The shift supervisor's note indicate that he spoke with Mr. Nugent who authorized that the restriction was to be served in a locked room (see notes in Attachment C). Accordingly, following the completion of intake procedures, Jennifer was placed in a locked room where she remained until 5:30 p.m. on Sunday when the shift supervisor, acting on his own, opened the door, noting that she had been compliant and that the room was very warm. On Monday, May 23, 1994, Jennifer was released to her home. Mr. Nugent stated during his interview that there must have been a failure of communication on Friday, May 20, because room confinement in these circumstances would not be consistent with their protocol and would be consistent with the definition of Class II abuse. We re-interviewed the shift supervisor who did not remember the specific conversation with Mr. Nugent but stated that he carefully documents such matters. Further, Mr. Nugent was inconsistent during his interview regarding both the policy and its application in this particular case.

Allegation 31: On or about March 12, 1994, Donna Fleming improperly authorized 24 hour room confinement for residents Raymond [redacted] and Lloyd [redacted]

Finding 31: Substantiated. The records for the above-referenced residents show that at approximately 9:30 p.m. on March 23, 1994, Scot Vinovich, supervisor on the second shift, gave the two residents a 24 hour restriction for "AWOL plan", On the morning of March 24, 1994, Donna Fleming ordered the restriction "[t]o be served in a locked room". The records contain no evidence of a hearing or authorization by the Detention Supervisor of the room confinement as required by policy. As stated in policy, Ms. Fleming exceeded her authority.

G. Ombudsman Policy

Allegation 32: "When we spoke of having the residents speak to their lawyers or fill out an ombudsman, we knew that the ombudsman would only be torn up and the resident would get in more trouble with Brad. Before an ombudsman form could be made out, a resident had to speak with the person involved, then to the person over them, and so forth. Some of the residents had asked for the forms and were refused." (Mary Roy, Karen Conlon)

Allegation 32A: "At this time, the policy and procedure concerning ombudsman had been altered by Brad so that any complainant had to speak with the staff person involved, then their supervisor, and finally Brad himself before filing could commence." (Brian Follansbee)

Allegation 32B: During their interviews, former staff members Karen Conlon and Lisa Ouellette estimated that at least one ombudsman form per month was given to residents. When informed that we could find very few of these forms they indicated their belief that supervisory staff simply destroyed the forms.

Allegation 32C: During her interview, former staff Vicki Chaski recalled that at separate times, Paul Nugent, Brad Asbury and Scot Vinovich threw out completed ombudsman forms.

Findings 32 A,B,C: Substantiated. Although supervisors denied that they would tear up the forms or refuse to give one to the resident, numerous staff who were interviewed indicated that supervisors minimized the process to the resident. Staff would give the form to the resident and state something to the effect that "It won't do you any good"; this statement could be perceived as threatening to the resident. The resident was offered no real recourse to address their complaint, no matter how frivolous it may appear to supervisory staff. Please see Recommendation 8.

Allegation 33: Resident Mark [redacted] completed an ombudsman form on April 2, 1993 in which he claimed that "when I was spitting on the floor, Mr. Asbury told me to wipe it up. I said no and kept doing it. He put me down, turned me around and wiped my face in it..." A post-it note signed by Paul Nugent was attached to this form stating: "No response developed. Mark was released to home."

Finding 33: Substantiated. Paul Nugent confirmed that it was his handwriting in the note and that it was not an appropriate response.

H. Inappropriate conversations between and among staff under circumstances where such conversations could be overheard by residents.

Allegation 34: A resident (Jenny [redacted]) reported to Vicki Chaski that she (Jenny) had overheard Donna Fleming tell Wendy Parker that "the kids sucked and were little pukes and that she hated her job and was only there for the money." (Vicki Chaski)

Allegation 35: Wendy Parker and Donna Fleming overheard by residents discussing their weekends of drinking and bar hopping. (Vicki Chaski, Wayne Eigabroadt)

Allegation 36: "When I worked on third shift, Donna would come in [in the morning] and sit in the office and talk with Rich and Chris [LaBerge]. All of their conversation was directed towards bad mouthing all the staff and residents. If I could hear everything they said, I could bet you so did the residents." (Vicki Chaski, Mary Roy)

Findings 34-36: Substantiated in part. We are unable to substantiate the specific conduct described in Allegations 34-36 because we could not identify third party witnesses and all people identified in the allegations denied such conduct. However, during the interviews, a substantial number of staff indicated that inappropriate conversations do take place in the "bubble". These conversations include swearing and derogatory comments about residents and staff. Because the "bubble" is not fully enclosed, it is likely that such conversations would be overheard by residents. Recognizing that staff occasionally will make inappropriate comments, the "bubble" should not be the place for conversations between staff about residents or other staff because of the likelihood that such conversations could be overheard by residents.

I. Other allegations concerning the mistreatment of residents

Allegation 37: [redacted]

Finding 37:

Allegation 38:

Finding 38:

Allegation 39: "[Resident] April [redacted] was going to a foster home, she asked if she could call her mom and was told "no" by Donna Fleming... So April went to a foster home and couldn't call out and her mother didn't know where she was or even how to contact her if she did." (Lora Reynolds)

Finding 39: Substantiated in part. Donna Fleming acknowledges that she may have refused to allow April access to the telephone outside of the normal calling hours. Ms. Fleming points out, however, that April's mother, Cindy [redacted] works at YDSU as a part-time Youth Counselor and would have access to April's placement information. Cindy [redacted] did not work the day that April went from the facility to the foster home.

Allegation 40: [redacted]

Finding 41: [redacted]

II. Allegations of Mistreatment of Staff

Allegations of mistreatment of staff are divided into two general categories: treatment of staff in the day-to-day operation of the facility; and, treatment of staff in personnel matters.

A. Treatment of staff in the day to day operation of the facility

Treatment of staff in the course of the day to day operations of the facility are grouped as follows: (1) verbal abuse (yelling, swearing, ridicule); (2) [redacted] (3) confidentiality; and (4) disputes within the various units within the facility (nursing, dorm, school). Treatment of staff in personnel matters are grouped as follows: (1)hiring; (2) promotion; (3) disciplinary actions; and [redacted]

1. Verbal Abuse (yelling, swearing, ridicule)

Allegation 42: Various staff members describe a meeting in Brad Asbury's office attended by Brad Asbury, Vinnie Urban, Pat Kenney and Paul Nugent to discuss an event where Mr. Urban had eavesdropped on a telephone call between Ida Quinones and Donna Fleming. All participants describe the meeting as loud and hostile; Mr. Asbury swore at Mr. Urban who stood up, assumed a fighting stance and threatened "to flatten" Mr. Asbury. Mr. Kenney became directly involved by slapping Mr. Urban's hands. The "meeting" continued in this manner, with all parties yelling and swearing until the participants finally settled down.

Finding 42: Substantiated. All people at the meeting described essentially the same facts. This conduct by some of the highest supervisory staff at the facility shows a lack of respect for one another and a complete absence of appropriate professional behavior.

Allegation 43: A number of staff report hearing Brad Asbury and Donna Fleming yelling at each other behind closed doors in Mr. Asbury's office. (Vicki Chaski, Muriel Ford)

Finding 43: Substantiated. Mr. Asbury did not deny the allegation and Ms. Fleming spoke openly about having "incredible headbutts" with Mr. Asbury. Ms. Fleming stated that we could ask anyone about their differences of opinion, thus implying that all could hear their yelling.

Allegation 44: Both Paul Nugent and Brad Asbury acknowledge that they often disagreed and that some disagreements were loud.

Finding 44: Substantiated. The two people directly involved in the conduct admit that this manner of interation occurred.

Allegation 45: [redacted]

Finding 45:

Allegation 46:

Finding 46:

Allegation 47: Debbie Levesque stated that following her report to John Sheriden of Rich LaBerge's swearing at resident Mark [redacted] in the time out room (see Allegation 8). "Paul Nugent came into my office and closed my door and proceeded to ream my butt," [stating] "the next time you wait until I come in and I'll handle it; I want things left on the third floor, first floor doesn't have to be bothered with incidents like that."

Finding 47: Substantiated. Mr. Nugent remembered the incident with resident Mark [redacted] and acknowledged that he spoke loudly with Ms. Levesque.

Allegation 48: Ellen Roche, one of the nurses on the night shift, reported an altercation with Rich LaBerge during the intake of a female resident where he yelled at Ellen over the issue of whether the resident's clothing should be "red bagged" because the resident had a skin rash akin to scabies. This altercation occurred in front of the resident who became hysterical.

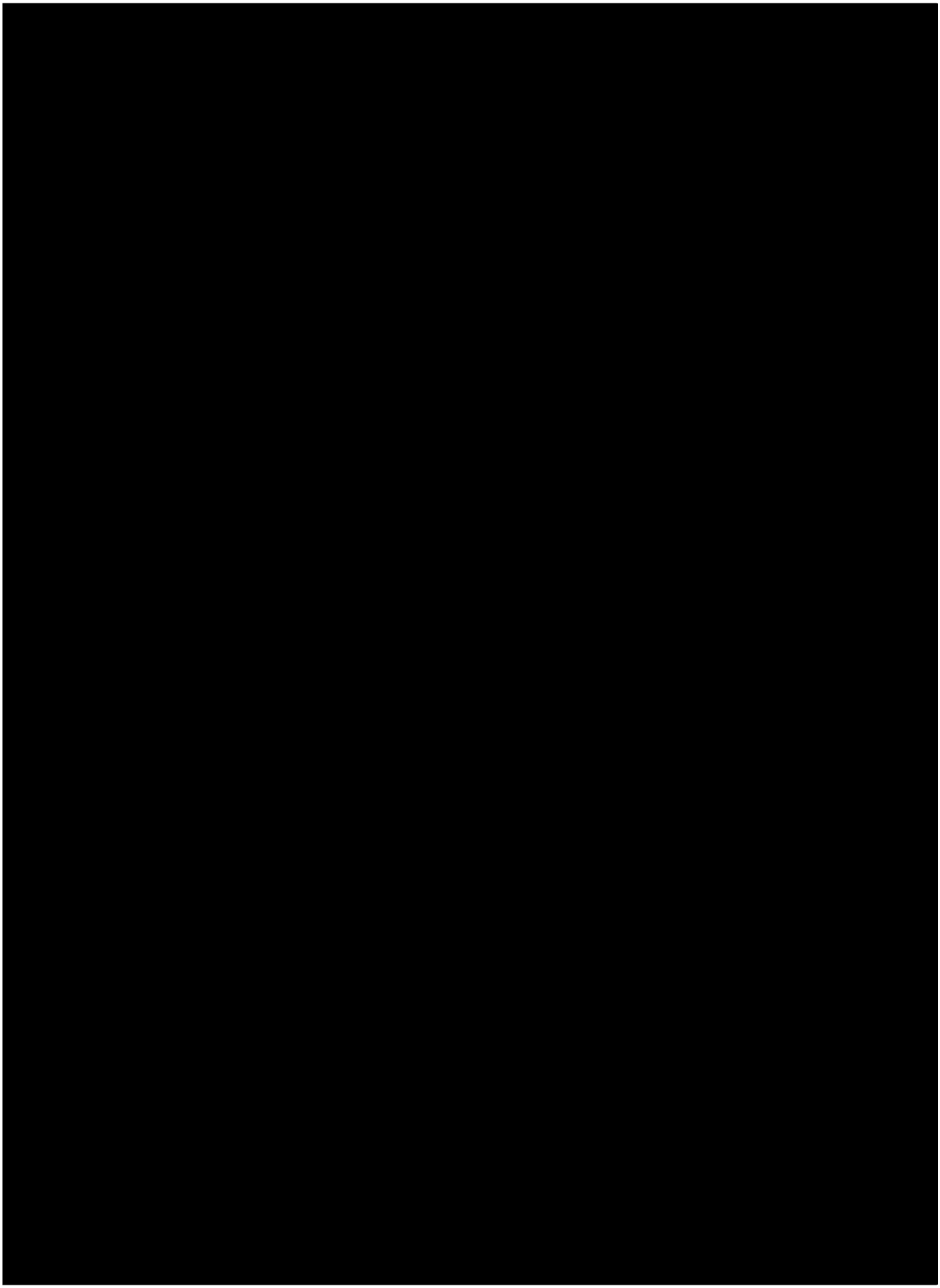
Finding 48: Substantiated. Rich LaBerge acknowledged that the decision of whether or not to "red bag" clothing was made by the nursing staff and described the interaction with Nurse Roche as "nasty".

Allegation 49: [redacted]

Finding 49:

2. [redacted]

[redacted]



3. [redacted]

[redacted]

B. Treatment of Staff in Personnel Matters (Hiring, Promotion, Disciplinary Matters and Scheduling/Time Off)

We received allegations in all personnel areas regarding the dormitory. Over the last four years, the dorm staff has been involved with several personnel decisions that we now believe established the tone of arbitrariness and favoritism that exists today. Within a year or so of arriving as House Leader, Brad Asbury was involved in the following decisions that are still discussed at the facility today: (1) The hiring as Youth Counselor I of his step-son Rich LaBerge, a carpenter by trade, who at the time of his initial hire had limited experience working with children; (2) the "voluntary" demotion of Frank Warden from a YCIII to a YCI; and (3) the defacto demotion of Assistant House Leader Michael LaChance to a YCI (by letter and in the presence of all staff, Mr. LaChance was informed that he would be the Assistant House Leader in name only but he would be viewed by all staff as a YCI. Mr. LaChance resigned soon thereafter). While we recognize that the then YDSU Supervisor Bill Wood likely directed or participated in the above-described actions, it is Mr. Asbury's involvement that was described to us. We received no allegations of mistreatment within the nursing unit by the nursing director. Allegations involving the teaching staff revolved around supervisory issues and disciplinary actions.

1. Hiring

The allegations about hiring involve only the dorm unit. Hiring for the dorm positions was done by "hiring boards" of three people appointed by the House Leader. From the interviews it appears that various dorm staff have served on hiring boards. However, we note that with few exceptions, Brad Asbury has served on all hiring boards and that Donna Fleming seems to be appointed to such boards with far greater frequency than do other staff members.

Allegation 57: [redacted]

Finding 57: [redacted]

Allegation 58: [redacted]

Finding 58: [redacted]

[redacted]

Allegation 61 [redacted]

Finding 61: [redacted]

2. Promotion

The allegations about promotion involve only the dorm unit. Promotion within the dorm was done by "promotional boards" composed of three people selected by the House Leader. From the interviews, it appears that various dorm staff have served on promotional boards. However, as noted in the section on hiring boards, it appears that, with few exceptions Brad Asbury served on

all promotional boards and Donna Fleming was appointed with far greater frequency than other staff.

Allegation 62:

Finding 62:

Allegation 63:

Finding 63:

Allegation 64:

Finding 64:

C. Disciplinary Matters.

Paul Nugent stated in his interview that when he came to the facility, a number of staff members spoke to him about their concerns rrding segataff mistreatment. As a result of these conversations and Mr. Nugent's review of a number of employee personnel files, he came to the conclusion that the facility's previous administration had not handled all disciplinary matters in a fair and appropriate manner. He spoke with Jay Collins and Sandy Platt and instituted a system whereby any proposed disciplinary action would be reviewed first by Jay Collins and then by Sandy Platt.

Allegation 65:

Finding 65:

Allegation 66:

Finding 66: [redacted]

4. [redacted]

[redacted]

III. Allegations that YDSU is a closed and hostile environment.

The control of personnel matters by the House Leader and Head Teacher; the perception of favoritism and unfairness created by the membership of hiring and promotional boards; the supervisory staff's failure to establish boundaries between their professional and personal lives; and the Detention Supervisor's failure to exercise appropriate oversight over the operations of the facility, when combined with the unprofessional manner in which supervisory staff dealt with each other and subordinates created an environment where a large number of staff are so fearful of retaliation that they would not approach their supervisors with concerns about mistreatment of residents and staff. Staff members who did take their concerns to supervisors do not believe their concerns were appropriately addressed by their supervisors.

Allegation 70: A number of staff indicated that they would not take concerns about resident or staff mistreatment to Mr. Asbury either because he was involved or modeled the mistreatment in question or the supervisor involved was a personal friend of Mr. Asbury and the staff member feared retaliation.

Finding 70: Substantiated. Based upon our interviews with numerous staff this allegation is substantiated. See Recomendation No. 3.

Allegation 71: At least five staff members separately shared with Paul Nugent and/or Jay Collins their concerns about mistreatment of residents and/or staff. These staff stated that Mr. Nugent and Mr. Collins had either taken no action or had addressed the action in such a manner that staff was retaliated against. (Vicki Chaski, Lora Reynolds, Scott McLean, Muriel Ford, Karen Conlon)

Finding 71: Substantiated. Based upon our interviews with numerous staff, this allegation is substantiated. See Recommendation No. 3.

Allegation 72: At least five staff members separately shared with Jay Collins their concerns about mistreatment of staff and residents at YDSU. All staff who did so indicated Mr. Collins took no action.

Finding 72: Substantiated. Mr. Collins stated that he communicated these concerns directly to Mr. Nugent, whom Mr. Collins trusted to investigate the allegations and make appropriate redress. As noted in Finding 71, Mr. Nugent did not act and Mr. Collins did not follow up with Mr. Nugent. There was no closure to the issue.

CONCLUSION

In addition to the substantiation of specific allegations regarding the treatment of residents and staff, we offer the following observations with concomitant recommendations. It is our strong sentiment that the substantiated allegations are symptoms of a facility that has been poorly operated, supervised and directed.

Observation 1: There are no management or organizational structures in place that facilitate collegiality and collaboration among the staff and among the primary work units (dormitory, educational and nursing). Management and supervisory staff have failed to recognize the importance of collaboration among staff and in some instances have fostered the divisiveness among their own staff as well as across other units. The result is that communication regarding residents, policies and issues is, at best, fragmented and dissemination of information occurs primarily through an informal network. Further, the expertise that each professional group has to offer regarding the needs of residents is lost.

Recommendation 1: Management and supervisory staff must acknowledge the value of collaboration and collegiality within the facility. The Superintendent must organize and hold regularly scheduled meetings with unit heads. The purpose of which is three fold: to resolve issues, policy interpretation questions and disputes; to ensure that integration among the units occurs at all levels; and to model appropriate behavior and expectations for subordinate staff. In addition, the Detention Supervisor should convene weekly meetings with the Head Teacher, House Leader and Assistant Director of Nursing to discuss operational issues and to devise strategies to meet the needs of specific residents. Further, during the change of shift meetings, nursing and teaching staff should be encouraged to participate. It is the responsibility of the House Leader to ensure that Shift Supervisors solicit the input and advice of other unit staff.

Observation 2: Communication within YDSU is fragmented and appears to occur primarily among informal systems. Given the strong divisiveness and the pervasive level of mistrust that exists among staff, communication (some of which is critical to the operation of YDSU) occurs primarily within "camps" or groups of staff. The result is that all staff do not possess the same knowledge base regarding the needs of the residents. This appears to occur

primarily across units, but is also evident particularly among the teaching staff. There are few, if any, forums for staff to communicate openly and honestly. There are no regularly held staff meetings, no regularly held supervisory meetings among departments, and an often canceled shift supervisors meetings. Consequently, communication among staff is usually around a negative event or disagreement. This method of negative interaction has become the "norm" within YDSU and occurs regularly in non-private areas, including hallways, the bubble (staff office), dining area, Mr. Asbury's office on the dormitory, and Mr. Nugent's office (contiguous to the classrooms). The residents, as well as other staff, can overhear these heated discussions and arguments. Key supervisory and management staff are responsible for this failure: they have not been positive role models nor have they provided the leadership necessary to encourage positive interactions and communication among staff and themselves.

Recommendation 2: Supervisory staff must receive intensive training regarding communication and supervisory skills development. There must be consistent and constant reinforcement by management staff that open communication and positive interactions are a priority. Management and supervisory staff must then demonstrate exemplary role modeling for subordinate staff. Further, the Superintendent or designee should hold monthly staff meetings for all three shifts in an effort to open up the communication channels and to foster positive interaction among staff.

Observation 3: Key staff have misused their supervisory positions and have been derelict in their duties. Jay Collins, Paul Nugent, Brad Asbury, Donna Fleming, Pat Kenney, and Richard LaBerge have not discharged their supervisory responsibilities in a manner that is equitable, impartial, consistent, positive and in some cases confidential. Specific allegations involving these individuals have been substantiated. The failure by these individuals to discharge their supervisory responsibilities effectively has resulted in the climate of mistrust and divisiveness that permeates YDSU. Supervisory staff have not intervened in an appropriate manner with residents and staff. They have not imparted a sense of trust or confidence to their subordinates. In fact, their behavior has engendered the strong perception by many that there is a climate of favoritism and partiality. This perception has become the reality at YDSU. Further, they have failed to provide a safe and therapeutic enviroment for the residents who are detained at the facility.

Recommendation 3: Given the seriousness of the allegations that are substantiated, the weight of the evidence, their own testimony and statements, we recommend disciplinary action be imposed for certain staff for dereliction of duty, misuse of their supervisory positions and engagement in unacceptable behavior toward residents and staff.

Jay Collins: As Superintendent, Mr. Collins deferred matters to his Detention Supervisor that Mr. Collins should have investigated directly. Further, he did not exercise sufficient oversight to ensure appropriate closure of issues and of investigations that were raised to him. The consequence of his actions resulted in either inaction or retribution by Mr. Nugent towards staff. Further, although Mr. Collins recognized that there were

communication issues among staff and weak managers, he did not proactively intervene in these matters. His decision to role model appropriate behavior and engage in a process of incremental change failed because he did not effectively articulate his expectation to the facility's supervisory staff. A severe letter of warning should be issued and placed in his personnel file.

Paul Nugent: [redacted]

Mr. Nugent, by his own admission and by the testimony of others, "wanted to be everyone's friend." Mr. Nugent failed to maintain the professional boundaries that are inherent with being a supervisor. Testimony supports that Mr. Nugent has lied to staff and is not trustworthy. That Mr. Nugent is duplicitous is corroborated by these investigators. Mr. Nugent changed his testimony several times during the course of his interview, and when presented with conflicting evidence, Mr. Nugent blamed a subordinate. Most importantly, Mr. Nugent did not exercise the necessary management oversight of YDSU: he did not review records to ensure consistency in treatment of residents and staff; he did not identify the changing needs of the resident population (as examples, residents with emotional problems and a larger female population); he did not ensure the consistent application of policy; and, he did not ensure the safety and well-being of residents in his care. The unwritten protocol for 24 hour room confinement (two days) could only be authorized by Mr. Nugent; resident Jennifer Dupont's locked door confinement as ordered by Mr. Nugent in May 1994 violated the unit's own unwritten policy. This act put Ms. Dupont in a potentially dangerous situation and constitutes Class II Abuse as defined by the facility's own policy on Child Abuse. Mr. Nugent should be terminated.

Patrick Kenney: During his interview, Mr. Kenney readily admitted to being an inadequate supervisor. He has engaged in capricious behavior merely to provoke a subordinate rather than to supervise the individual in a professional manner. Mr. Kenney recognized that there are strong divisions among his own five person department and yet has not intervened to resolve the issues. By not confronting the issues and by not respecting a diversity of teaching styles, Mr. Kenney has contributed to an environment where his staff are not fully informed about the behavior and needs of the residents. Further, by not addressing his own supervisory deficiencies. Mr. Kenney has not gained perspective on managing his staff. Mr. Kenney's own behavior during the December 1993 meeting with Vinnie Urban, Brad Asbury and Paul Nugent was unprofessional. A severe letter of warning with a copy in his personnel file should be issued.

Bradley Asbury: As House Leader, Mr. Asbury has responsibility to ensure that the policies and protocols within the dormitory are discharged fairly and consistently. Dormitory staff were quite capable of reciting the different levels of restrictions to us; however, when queried as to who could authorize the use of restriction, there were varied and inconsistent responses. The staff

handbook and policies were clear, and yet the staff were not. The weight of the evidence substantiates that Mr. Asbury becomes angry and yells at supervisory staff in locations where residents can overhear. Mr. Asbury's actions during a meeting between Vinnie Urban, Pat Kenney, and Paul Nugent were undignified and unconscionable given his position as a supervisor. Although Mr. Asbury recognized the significant weakness of subordinates, most notably Rich LaBerge and Donna Fleming, he provided generally excellent evaluations of same. [redacted] Although Mr. Asbury recognized poor communication among nursing and some teaching staff, he did not take the steps necessary to resolve these communication problems. In addition, Mr. Asbury did not sanction the usefulness of and merit to the client grievance process. Mr. Asbury has been derelict in the discharge of his supervisory responsibilities; his actions have directly contributed to the climate of mistrust that currently exists. Mr. Asbury should be terminated.

Richard LaBerge: As a Youth Counselor III, Mr. LaBerge has responsibility to ensure that his shift operates smoothly, that the policies and protocols are consistently implemented, and that he project a positive role model for staff and residents. The weight of the evidence substantiates that Mr. LaBerge has an "explosive" temperament and can be easily "set off." Mr. LaBerge is combative with staff and residents alike. It has been substantiated that he swore at a resident during a restraint procedure; that he provoked several residents, at least one of whom had emotional difficulties into having tantrums; and that he became argumentative with another nursing staff in front of a resident. Further, Mr. LaBerge ridiculed staff in a non-enclosed room thus allowing both staff and residents to overhear his conversations. Mr. LaBerge did not provide a safe and therapeutic environment for the residents. Mr. LaBerge should be terminated.

Donna Fleming: As a Youth Counselor III, Ms. Fleming has responsibility to ensure that her shift operates smoothly, that the policies and protocols are consistently implemented and that she project a positive role model for staff and residents. She has engaged in willful misuse of her supervisory position. Ms. Fleming is combative with colleagues, whether they are teaching, supervisory, support or nursing staff. Her manner of interaction is argumentative and confrontational. Her behavior does not provide a positive image for staff and residents. Further, by her own admission, she engages in "head butting" discussions with her supervisors that can be overheard by others. She acknowledges that she does not like interacting with female residents thus contributing to the perception that female and male residents are treated differently. Ms. Fleming has engaged in conduct that shows a lack of respect for the residents as documented on her shift supervisory notes. Ms. Fleming exceeded her authority by authorizing the use of locked door, room confinement for two residents in violation of written policy and procedures. She failed to provide a safe and therapeutic

enviroment. A severe letter of warning with optional dismissal should be issued to Ms. Fleming, a copy of which is pplaced in her personnel file.

Vincent Urban: Mr. Urban has engaged in unprofessional conduct as a teacher. He has not maintained positive working relationships with his peers and supervisors. He has admitted to eavesdropping on a telephone conversation between two staff members and has engaged in a potentially explosive situation with colleagues. A severe letter of warning with a copy to his personnel file should be issued.

Observation 4: Dorm staff engage in physical activities with the residents; given the physical conditioning of many staff, these games become highly competitive. Further, the residents are often divided into two groups: older and physically larger male residents; and, all females with the younger males. The stretch and flex program is defined as a high impact, aerobics workout, and thus may not be appropriate for all residents. Although residents may elect to not participate, they are segregated from the group and receive consequences for this decision.

Recommendation 4: It is our strong recommendation that the gym activities and recreational programs be thoroughly reviewed and revised. An outside consultant should be utilized for this purpose. Specifically, we have strong reservations regarding staff directly participating in contact sports. It is appropriate for staff to coach, to teach and to demonstrate; however, given the keen competitive spirit and physical conditioning of the staff, we question the appropriateness of direct participation with the residents. In fact, a number of staff refer to "notching up the games" when they play; this seems inappropriate. Stretch and flex should be reviewed in light of the general physical conditioning of the residents; the availability of both high and low impact aerobics should be explored. The scheduling of recreational opportunities should be reviewed to determine if a different grouping of residents can be arranged. For example, residents could be assembled into three groups rather than the existing groupings. As a final note, there should be no consequences for residents who elect to not participate in these activities.

Observation 5: As a 24 hour facility, the dorm staff has a highly unusual and inconsistent staffing schedule. Some direct care staff are on a regular work schedule (Monday through Friday, weekends off) while other staff have a four day work week with a fifteen hour day during a weekend. Further, the lack of an appropriate number of part-time staff with a reasonable gender mix contributes to difficulty in covering staff vacancies, leave time, etc. The current schedule appears to favor the needs of the staff rather than the needs of the facility and its residents.

Recommendation 5: A thorough review of the staffing schedule and the needs of the unit should be immediately reviewed and revised as necessary. A 15 hour shift is not healthy nor productive for employees. Consideration should be given to re-deploying dorm staff on the day shift to the evening hours in order to provide better overall coverage; the reality is that during the week, residents are scheduled to be in class with the teaching staff (5.75 FTES).

Observation 6: A majority of residents detained at YDSU have significant emotional difficulties. More than 30% are coded as educationally disabled and the population regularly contains youth experiencing behaviors associated with abuse such as bed wetting and eating disorders. Although a short-term facility, YDSU could offer a brief, therapeutic intervention for the residents through the provision of psycho-educational groups and brief counseling services. It must be noted, however, that the majority of direct care staff have limited educational and/or experiential foundations in order to offer these services. In general, the nursing staff has much stronger skills and knowledge in these areas.

Recommendation 6: Training should be made available to increase the therapeutic skills of the direct care staff. Nursing staff, direct care staff and consultants should design and implement a variety of psycho-educational groups and health forums for the residents. All groups should be led by a professional with a para-professional (youth counselor) as co-facilitator.

Observation 7: During the course of the investigation, we discovered that a number of unwritten protocols existed and that several key policies were missing (i.e., bedwetting procedures; management of residents with emotional difficulties). Furthermore, staff were inconsistent in their understanding of the supervisory hierarchy for authorizing restrictions. For example, although the rules governing chair restrictions were established by written policy which was summarized in the staff handbook, we found there to be little consistency in staff implementation of these policies. A number of youth counselors felt they could give a 4 hour restriction without supervisor approval. There was also inconsistency among staff on the issue of who could authorize longer restrictions (up to 24 hours) and whether supervisor approval was necessary to restart a restriction. The fact that the basic rules of the cornerstone of the behavior modification program then in effect were not uniformly interpreted by all staff raises substantial questions regarding supervision.

Further, we discovered that a number of practices and procedures that were regularly utilized by staff did not appear in writing. These included the practice of requiring residents to serve restriction time owed from a previous admission to YDSU. A second unwritten practice was the requirement that any resident who had been administratively transferred to a shelter care facility and had returned to YDSU (for AWOL, assault, etc.) would immediately upon their return, begin serving a 24 hour restriction. Additional unwritten practices included the restarting of a restriction if a resident is non-compliant and/or requiring a resident to serve a restriction outside the normal hours of 7:00 a.m. - 8:00 p.m. As with the lack of uniform understanding of the written policies governing chair/room restriction, the existence of a substantial number of unwritten protocols concerning a central component of the facility's behavior management program raises questions about the quality of management in the development of policy and quality of the supervision in the implementation of policy.

Recommendation 7: All unwritten protocols should be reviewed by management staff and either accepted or abolished as policy. The unwritten protocols utilized at YDSU clearly provided greater restrictions in an existing restrictive environment. Management must ensure that this practice of unwritten protocols not be allowed.

Observation 8: The Ombudsman Policy in both concept and in implementation is flawed. There is no resident rights statement posted in the facility. Staff did not believe in the integrity and importance of a client's rights policy.

Recommendation 8: All staff in the facility must affirm their belief in the protection of the basic rights of residents. Posted throughout the facility should be clear statements regarding resident rights and the complaint process; these statements should be written in English and Spanish. Upon request, residents should be given a complaint form, writing instrument, envelope addressed to the Superintendent, and staff assistance if requested. Upon completion, it would be the Shift Supervisor's responsibility to note the receipt of a complaint and forward it to the Superintendent. It is the responsibility of the Superintendent to investigate the complaint and to bring closure to the issue. On a monthly basis, a report of all complaints and the subsequent outcomes are to be submitted to DCYF Central Office.

Observation 9:

Recommendation 9:

Observation 10: There is no ongoing quality assurance program in existence at the facility nor is there any regulatory oversight from an external group. The facility is neither certified nor accredited. The absence of an ongoing quality assurance system has contributed to the problems existing at YDSU for an extended period of time. And, although the mission of YDSU includes the provision of ". . . residential care and education in a safe and healthy environment to the youth", the facility operates along the lines of a correctional facility.

Recommendation 10: The Division must reaffirm that the mission of YDSU is to provide a safe and healthy environment and must assure that all operating policies and procedures are consistent to that mission. The Division should determine if the facility should be certified by a nationally recognized accreditation organization; and if so, management staff should direct its activities to achieve such certification. By joining a professionally recognized organization, the facility will have access to state of the art information, to other professionals in the field, and for being reviewed by an external group. In addition, the superintendent in concert with DCYF state office must design and implement a continuous process for improving operations. At a minimum, this should include: review of documentation and record keeping systems; review of restriction practices by individual staff; personnel matters, etc... In addition, management staff should conduct unannounced site visits on all three shifts to gain first hand knowledge about operations.

Observation 11: Certain job descriptions are not clear in relation to other labor grades within the dormitory; and the qualifications for some titles are either too vague or too restrictive. For example, individuals hired to the position of Youth Counselor I do not seem to possess skills necessary to work with youth. Under Brad Asbury, hires have included a laid-off postal worker, a carpenter, a land surveyor, and a terminated adult group home worker. Qualifications for a Youth Counselor I requires "one year's experience working with youths in group activities such as camp counseling, Boy or Girl Scouts, church activities or related experience." Additionally, it appears that Mr. Asbury has circumvented the qualifications requirement for YCI by hiring individuals as trainees and as a part-time employees in order to gain the minimum requirements for certification. Further, the role and responsibility of the Assistant House Leader vis-à-vis the Youth Counselor III position is not clear; in fact, the job description for the YCIII includes greater responsibilities even though it is the lower labor grade. Qualifications for the Detention Unit Supervisor requires prior experience as a House Leader.

Recommendation 11: A full review and revision, as necessary, of the supplemental job descriptions for the following positions should occur: Detention Supervisor; House Leader; Assistant House Leader; and, the Youth Counselor series. Roles and responsibilities should be developed in a manner that reflects the organizational hierarchy of YDSU. We strongly recommend that the qualifications for the Detention Supervisor be expanded to include prior experience as House Leader or equivalent experience as Juvenile Service Officer, etc... The experience for Youth Counselor I should be clarified and made more definitive regarding previous experience with youth. Finally, the process for hiring should be expanded; recruitment of qualified staff should be made a priority by supervisory staff. Hiring should not be the responsibility of the House Leader; in our opinion, hiring should be the responsibility of the Detention Supervisor. The practice of hiring non-certifiable individuals as part-time employees should desist as a practice. There should be a roster of part-time, trained employees available for coverage purposes; but it should not

be utilized as the primary mechanism to enter into the state system as a Youth Counsellor. This practice has led to the hiring, in some cases, of minimally qualified individuals.

Appendix A

Youth Detention Secure Unit: chronology of the Investigation

DATE	EVENT
5-31-94	Lora Reynolds, Youth Counselor II at YDSU meets with Lorrie Lutz. Raises issues concerning child and staff mistreatment and management failures at YDSU, and expresses fear of retaliation by supervisors.
6-4-94	Lorrie Lutz and Sandra Platt, Human Resources Coordinator for the Department of Health and Human Services meet with 16 current and former staff of YDSU. Staff cite incidence of abuse by staff of residents and by supervisors of staff. Discussion includes examples of arbitrary schedule changes, targeting staff for retaliatory purposes, inappropriate behavior, lying, residents being abused (yelling, hitting, swearing, being humiliated), abuse of restraints, and [redacted] Participants at the meeting agree to submit written statements.
6-6-94	Lorrie Lutz meets with YDSU management staff, Jay Collins, Brad Asbury, Paul Nugent and John Sheridan and details the following actions including: revoking the use of chair restriction; mandating that Ombudsman reports be submitted directly to the Director's office; and, assuming direct responsibility for all personnel actions. (Ms. Lutz sends letter to all staff revoking chair restriction policy).
6-8-94	Lorrie Lutz assigns Lynette Rose and Egan Jensen to YDSU to provide additional support to Superintendent Jay Collins. Lorrie Lutz meets with staff regarding revocation of chair restriction and discusses the new treatment philosophy.
6-10-94	Marylou Sudders and Tricia Lucas meet with Lorrie Lutz and Sandra Platt to review allegations and agree to investigate. Office of Attorney General approves the investigation.
6-13-94	Marylou Sudders calls Jay Collins, Superintendent, to inform him that the security of all records are his responsibility. Bradley Asbury, House Leader is suspended with pay pending the outcome of the investigation pursuant to a letter from the Commissioner's Office.
6-14-94 thru 6-30-94 and 7-7-94	Investigators hold 42 interviews with 39 individuals, review more than 20 client records, tour the unit, and review a multitude of documents, including restraint, supervisory and communication logs, rule violation hearings, reports and personnel records.
7-8-94	Investigators submit their investigation report to Office of the Attorney General and Director Lutz.

Appendix B

YDSU Investigation: Individuals Interviewed

DATE	NAME	TITLE	STATUS
6-14 & 6-28	Jay Collins	Superintendent	Full-time
6-15	Michael Blake	Teacher	Full-time
6-16	Lora Reynolds	Youth Counselor II	Full-time
6-16	Frank Warden	Youth Counselor I	Full-time
6-16	Muriel Ford	Registered Nurse II	Full-time
6-16	Scott MacLean	Nursing Director	Full-time
6-16	Michelle Koski	Youth Counselor II	Full-time
6-16	Brian Follansbee	Youth Counselor I	Full-time
6-17	Wendy Parker	Youth Counselor I	Full-time
6-17	Pat Kenney	Head Teacher	Full-time
6-17	Jeff Lauderdale	Chef I	Full-time
6-17	Peter Bukowski	Recreational Therapist II	Full-time
6-20	Christopher LaBerge	Youth Counselor I	Full-time
6-20	Karen Conlon	*Former* Youth Counselor I	former Full-time
6-20	Jonathan Brand	Youth Counselor I	Full-time
6-20	Gary Blake	Acting Assistant House Leader	Full-time
6-20	Ellen Roche	Registered Nurse	Full-time
6-20	Lisa Ouellette	*Former* Youth Counselor I	former Part-time
6-20 & 6-29	Donna Fleming	Youth Counselor III	Full-time
6-20	Debbie Levesque	Executive Secretary	Full-time
6-21	Gail Meinhold	Youth Counselor I	Full-time
6-21	Rich LaBerge	Youth Counselor III	Full-time
6-22 & 6-30	Scott Vinovich	Youth Counselor III	Full-time
6-22	Joanne Ferry	*Former* Youth Counselor II	former Full-time
6-22	Joanne Wood	Teacher	Full-time
6-22	Michael LaChance	*Former* Assistant House Leader	former Full-time
6-22	Vincent Urban	Teacher	Full-time
6-22	Wayne Eigabroadt	Assistant House Leader	Full-time
		(out on Workman's comp since 5/93)	Full-time
6-22	George Kalampalikis	Youth Counselor I	Full-time
6-22	Joyce Johnson	Registered Nurse II	Part-time
6-23	Louis Kalamplinkis	Teacher's Aide	Full-time
6-24 & 6-28	Brad Asbury	House Leader	Full-time
6-27	Jeff Mills	Youth Counselor II	Full-time
6-27	Paul Nugent	Supervisor III	Full-time
6-27	Robert Lynch	Youth Counselor I	Part-time
6-28	Mike Fitzpatrick	Teacher	Full-time
6-29	Ida Quinones	Youth Counselor II	Full-time
7-7	Victoria Chaski	*Former* Youth Counselor I	former Full-time
7-7	Mary Roy	Youth Counselor II	Full-time

APPENDIX C